COVER PAGE NOTE:
THIS IS A DRAFT LME Waiver Entity Contract Template

Between
The North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

And

LME Name…

IMPORTANT NOTE TO ANY LME RESPONDING TO THE "REQUEST FOR APPLICATION" AS IT RELATES TO THE 1915 B/C WAIVER EXPANSION PROJECT:

THIS IS A "DRAFT SAMPLE CONTRACT"

– NOT FOR PURPOSES TO BEGIN NEGOTIATIONS –

RATHER THE DRAFT CONTRACT IS FOR THE PURPOSE OF REVIEW AND UNDERSTANDING THE WAIVER ENTITY RESPONSIBILITIES AND REQUIREMENTS.

CONTRACT IS SUBJECT TO CHANGE BASED UPON WAIVER ENTITY SUBMITTED RESPONSE TO THE RFA IF APPLICATION IS ACCEPTED BY THE DHHS AND THE RFA REVIEW COMMITTEE.

CONTRACT IS SUBJECT TO CHANGE BASED UPON THE DMH/DD/SAS & DMA - AG REPRESENTATIVES APPROVAL OF THE CONTRACT FOR AND / IF A LME IS SELECTED TO OPERATE A PIHP.

CONTRACT IS ALSO SUBJECT TO CHANGE BASED UPON ANY ACCEPTED CHANGES TO THE TEMPLATE "DHHS – LME PERFORMANCE CONTRACT" TEMPLATE AND AS IT RELATES TO EITHER ALL LMES OR SPECIFIC TO A WAIVER ENTITY APPLYING TO OPERATE A PIHP>

ATTACHMENT II & Section 3.0

1. System Performance Indicators are subject to be adjusted prior to actual contracting due specific alignment of an updated DHHS LME Performance Contract changes and with DMA Quality Performance Measures expected of the Waiver Entity.

2. Standardized Encounter Data and Data submission is required and dependent upon the acceptance of Medicaid data and DHHS going on line of the new OMMIS system, a Waiver Entity may need to down load encounter data back to start date of the new waiver entity.

ATTACHMENT III FINANCING

3. DMHDDSAS funding is subject to change in this sample waiver entity contract based upon several variables still to be negotiated with the DHHS, DMHDDSAS and DSOHF and any actions by the General Assembly.

CONTRACT # _____

Between
The North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

And

LME NAME
(LME operating as a MCO)

FEDERAL TAX ID # _____

1.0 Parties to the Contract

This Contract is entered into by and between the North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services, hereinafter referred to "Division" or "DMH/DD/SAS, (which is a Division under the North Carolina Department of Health and Human Services hereinafter referred to as the "Department" or "DHHS") and LME NAME, a political subdivision of the State of North Carolina, hereinafter referred to as the "Local Management Entity" or "LME" or LME NAME.

2.0 Terms of Contract

The term of this contract shall be for a period, commencing January 01, 2012 and ending June 30, 20??.

3.0 Contract Documents

The following documents are incorporated herein by reference:

(1) Attachment I – Scope of Work
(2) Attachment II – Performance Measures
(3) Attachment III – Financing
(4) Attachment IV – Data Use Agreement
(5) Attachment V – The *LME NAME* Waiver Project
(6) Attachment VI – Baseline for Single Stream Funding

In the event of a conflict in terms between the Contract Documents, the documents will be accorded precedence in the following order: the Contract, Attachment I - Scope of Work, Attachment II – Performance Measures, Attachment III – Financing, Attachment IV –Agreement to Share Data, Attachment V – The *LME NAME* Waiver Project, and Attachment VI – Baseline for Single Stream Funding. Portions of this Contract relating to Medicaid financing and Medicaid services may require approval by the federal Centers for Medicare and Medicaid (CMS). Nothing in this Contract or the referenced Attachments shall be construed to create an entitlement to services purchased with State or State-allocated federal funds.

4.0 Assignment

No assignment of the LME's obligations or the LME's right to receive payment hereunder shall be permitted. However, when assignments are made pursuant to changes in governance or counties participating in an LME, assignments may be made with prior written approval of DMHDDSAS, which approval will not be unreasonably withheld. Upon such approved assignment, the assigned contract will be deemed a novation.

5.0 Subcontracting

The LME may subcontract the functions contemplated under this Contract. The LME shall be responsible for the performance of any subcontractor. The LME shall establish procedures for the oversight, monitoring and evaluation of subcontractors to ensure accurate reporting and appropriate use of State funds. The LME may not contract out the roles and/or responsibilities of the LME Director and the Chief Finance Officer as employees of the LME.

6.0 Beneficiary

Except as herein specifically provided otherwise, this Contract shall inure to the benefit of and be binding upon the parties hereto and their respective successors. It is expressly understood and agreed that the enforcement of the terms and conditions of this Contract and all rights of action relating to such enforcement, shall be strictly reserved to the Department and the LME. Nothing contained in this document shall give or allow any claim or right of action whatsoever by any other third person. It is the express intention of the Department and LME that any person or entity, other than the Department or the LME receiving services or benefits under this Contract shall be deemed an incidental beneficiary only.

7.0 Entire Agreement

This Contract and any documents incorporated specifically by reference represent the entire agreement between the parties and supersede all prior oral or written statements or agreements, with the exception of the DMA Provider Agreement between the *LME NAME* and DMA and the contracts between the LME and the individual institutions of the DMH/DD/SAS and/or Divisions of the Department.

8.0 Availability of Funds

The parties to this Contract agree and understand that the payment of the sums specified in this Contract is dependent and contingent upon the appropriation, allocation and availability of funds for this purpose to DHHS, DMHDDSAS and the LME.

9.0 Responsibilities of the Department

The responsibilities of the Department are as follows:

(1) Certify the LME's Local Business Plan (LBP), prepared in accordance with DHHS requirements and G.S. §122C-115.2(c);
(2) Certify the catchment area of an LME, area authority or a county program shall meet a minimum population of at least 300,000 as of July 1, 2012 and as July 1,

2013 shall be a minimum population of 500,000 in becoming a 1915 b/c Waiver Entity.

(3) Monitor the LME to comply with the requirements of G.S. 122C-115; and provided further that nothing contained herein shall limit the Secretary's authority to suspend funding pursuant to G.S. §§122C-124.1 and 147; and the agreed upon minimum requirements as established in the RFA, the LME application response to the RFA issued by DHHS, and in conjunction with this contract and the DMA contract for the purposes of the LME operating as a PIHP.
(4) Monitor the LME for compliance with the terms of this Contract and publish individual and comparative reports regarding the LME's performance under this contract;
(5) Notify in a timely manner the LME of changes in covered services or conditions of providing covered administrative services;
(6) Participate in the intra-Departmental monitoring team;
(7) Collaborate with the LME on quality improvement activities, fraud and abuse issues, and other activities that impact the services provided to recipients;
(8) Except when business conditions dictate adherence to a less than 90 day implementation timeline (e.g. changes in federal law regulations or policy; changes in state law or regulation, or business conditions which necessitate a more expedient implementation), DMHDDSAS will notify LMEs of policy or procedure changes 90 days prior to effective date of change;
(9) All other responsibilities contained in this Contract;
(10) Review the contract annually.
(11) De-categorize all state funding to the extent possible within the requirements and restrictions of the SAPTBG, CMHSBG, SSBG, and their accompanying state MOE requirements, the PATH Program federal formula grant, SPF-SIG, SDFSCA, and other federally funded or designated projects. Any federal or state funds shall remain designated that are appropriated or approved by the NC General Assembly, or granted by the federal government for a specific population, program, or service, or that are otherwise circumscribed in this contract.

10.0 Responsibilities of the LME

The responsibilities of the LME are as follows:

(1) Serve as a Local Management Entity (LME), operating a PIHP, for public mental health, developmental disabilities and substance abuse services in the LME's designed geographic territory either in a contiguous or in a non-contiguous business arrangement.
(2) The LME will implement the RFA as accepted by DHHS, perform the functions described in the RFA in accordance with its terms and the terms of this Contract and the DMA contract;
(3) Perform the functions outlined in Attachment I - Scope of Work;
(4) Manage service capacity and quality via enforcement of DHHS and Division policy and applicable state and federal statutes including termination for cause of Waiver Entity - Provider contracts;
(5) Be wholly responsible for the work to be performed and for the supervision of its employees. The LME represents that it has, or shall secure at its own expense all personnel required in performing the services under this Agreement. Such

employees shall not be employees of the Department, for the purpose of this contract;

(6) Utilize State and non-Medicaid federal funds allocated for services under this contract for Division approved mental health, developmental disabilities and substance abuse services for individuals in the catchment area in accordance with approved DMHDDSAS Target Population categories or those served in Cross Area Service Programs (CASPs).

(7) Submit to the Department all plans, data, reports or documents required by statute or duly adopted regulation, state or federal funding agreements, DMHDDSAS policy and this Contract;

(8) Monitor sub grantees for compliance with the terms of subcontracts and ensure that sub grantees comply with all reporting requirements of the LME and DMHDDSAS;

(9) Allow the Department, DMHDDSAS, and DMA unrestricted access to all public meetings, activities, and documents pertaining to the fulfillment of functions or activities funded by this contract;

(10) Contract with any Medicaid provider agency for billing purposes only when that agency does not have the ability to directly enroll with the DMA;

(11) Subject to funds availability implement the approved LME crisis plan;

(12) Crosswalk consumers to the Client Name Data Service (CNDS) when the consumers are enrolled into the Consumer Data Warehouse (CDW) or other required Departmental data systems.

(13) Accurate and timely submission of CDW, PCP, NC-TOPPS, IPRS target population eligibility, and other Division required data for each consumer as required by Division policy or other required Departmental data system.

(14) Set rates for services, determine financial incentives, sanctions and set financial limits on contracts.

(15) Provide enhanced care management services to consumers with mh/dd/sa needs deemed as high risk / high cost.

(16) Provide to the Division copies of all reports sent to DMA as a member of the inter-departmental team.

(17) All other responsibilities contained in this Contract;

(18) Submit required cost reports (if applicable).

(19) To meet all of the minimum requirements of the RFA on an on-going basis.

11.0 Accreditation for Management Functions

LME shall have evidence of a three year accreditation from a national accreditation body approved by the State and within one year from the initial date of this contract, as a waiver entity operating a PIHP, shall have achieved accreditation either from NCQA or URAC.

12.0 Accreditation for Direct Services

Under the terms of this contract a LME shall be divested of all service delivery.

13.0 Notice of Certain Reporting and Audit Requirements

The LME shall use or expend the funds available under this contract only for the purposes for which they were appropriated by the General Assembly or received by the State. State funds include federal funds that flow through the State. The LME is subject to the requirements of OMB Circular A-133 and the N.C. Single Audit Implementation Act of 1987, as amended in 1996.

The LME shall furnish to the State Auditor, upon his/her request, all books, records and other information that the State Auditor needs to fully account for the use and expenditure of state funds.

The LME shall ensure that in all LME expenditures and reimbursements using state and federal funds, and in all LME subcontracting with entities that are eligible to receive these funds, the LME staff and its subcontractors shall fully comply with all requirements and restrictions of the SAPTBG, CMHSBG, SSBG, and their accompanying state MOE requirements, PATH formula grant, SPF-SIG, SDFSCA, and all other applicable federal grant program funds. The LME shall apprise all staff and contractors in writing of the requirements and restrictions of these funding sources and shall monitor compliance with these requirements and restrictions.

If the LME disburses or transfers state funds to other organizations other than for the purchase of goods or services, the LME will require the recipient(s) to file reports and statements required in G.S. § 143C 6-22 and 6-23 and the State Auditor's Audit Advisory # ADV-2005-001.

If any funds available to the LME under this contract are passed through the LME to another organization as financial assistance, those funds will require monitoring in accordance with OMB Circular A-133 and G.S. §§ 143C 6-22 and 6-23. The LME shall establish procedures for the oversight, monitoring and evaluation of sub grantees to ensure accurate reporting and appropriate use of State funds.

14.0 Record Retention

Both parties shall retain records at their own expense in accordance with applicable requirements. At a minimum, parties will maintain all grant records for a period of five years after the grant closes or until all audit exceptions, litigation, claims or other official action involving the records have been resolved, whichever is longer.

In order to protect documents and public records that may be involved in DHHS litigation, the Department will notify the LME when documents may be destroyed, disposed of, or otherwise purged through the biannual Records Retention and Disposition Memorandum from the DHHS Controller's Office.

LMEs are also subject to the requirements of the Records Retention and Disposition Schedule for State and Area Facilities (APSM 10-3).

The LME shall facilitate and monitor the compliance of its providers with applicable records retention and disposition requirements.

When a provider abandons records, the LME shall take possession of the abandoned records and notify all DHHS state agencies involved with associated provider including but not limited to DMA, DMHDDSAS, DHSR, and accreditation organizations.

When an LME dissolves, and/or merged with a successor organization, the successor organization is obligated to assume responsibility for the records of the dissolved LME for the duration of the retention schedule for those records per the Records Retention and Disposition Schedule for State and Area Facilities (APSM 10-3). This includes client records, administrative records and other records covered by the retention schedule. The successor LME has the option of scanning the records and disposing of the paper copies or renting storage space and retaining the records in storage. These records can be disposed of when the retention schedule for the records has been met. Records which have met the retention schedule shall be destroyed if these records are not subject to audit, investigation, or litigation.

15.0 Liabilities and Legal Obligations

Each party hereto agrees to be responsible for its own liabilities and that of its officers, employees, agents or representatives arising out of this Contract.

16.0 Compliance with Laws

The LME and the Department shall comply with all laws, ordinances, codes, rules, regulations, and licensing requirements that are applicable to the conduct of its business, including those of federal, state, and local agencies having jurisdiction and/or authority.

The LME shall ensure that in all LME expenditures and reimbursements using state and federal funds, and in all LME subcontracting with entities that are eligible to receive these funds, the LME staff and its subcontractors shall fully comply with all requirements and restrictions of the SAPTBG, CMHSBG, SSBG, and their accompanying state MOE requirements, PATH formula grant, SPF-SIG, SDFSCA, and all other applicable federal grant program funds. The LME shall apprise all staff and contractors in writing of the requirements and restrictions of these funding sources and shall monitor compliance with these requirements and restrictions.

17.0 Amendment

All amendments shall be made in written form and executed by duly authorized representatives of the DMHDDSAS and the LME. This contract may not be amended orally or by performance. DHHS may unilaterally amend the terms of this Contract if it removes any one or more of the LME's functions pursuant to Chapter 122C of the North Carolina General Statutes. The parties agree that this contract will be amended, as necessary, to maintain compliance with State or federal law, regulations or policy.

18.0 Choice of Law

The laws of the State of North Carolina shall govern and control this Contract. The parties agree that in litigation initiated by the LME, related to matters concerning this Contract, venue for legal proceedings shall be Wake County, North Carolina. The parties further agree that in any action initiated by DHHS against the LME under or arising from or involving the validity, construction, interpretation or enforcement of this contract, venue will be appropriate in the County where the LME's primary administrative office is located.

19.0 Federal Certifications

The LME agrees to execute the following federal certifications:

(1) Certification Regarding Lobbying;
(2) Certification Regarding Debarment;
(3) Certification Regarding Drug-Free Workplace Requirements;
(4) Certification Regarding Environmental Tobacco Smoke.

20.0 Severability

In the event that a court of competent jurisdiction holds that a provision or requirement of this Contract violates any applicable law, each such provision or requirement shall continue to be enforced to the extent that it is not in violation of law or is not otherwise unenforceable and all other provisions and requirements of this Contract shall remain in full force and effect.

21.0 Confidentiality

Any medical records, personnel information or other items exempt from the NC Public Records Act or otherwise protected by law from disclosure given to the LME under this contract shall be kept confidential and not divulged or made available to any individual or organization without the prior written approval of DHHS except as otherwise provided by law. The provisions of 42 CFR, Part 2 – Confidentiality of Alcohol and Drug Abuse Patient Records and HIPAA shall be fully applicable.

22.0 Termination

a. For Convenience: This agreement may be terminated for convenience at any time by the mutual written agreement of the parties without additional liability to either party.

b. For Cause: Pursuant to G.S. § 122C-125, this contract is terminable for cause by DMHDDSAS. Additionally, pursuant to Chapter 122C of the North Carolina General Statutes, DMHDDSAS may remove certain duties and responsibilities from the LME and may suspend funding to the LME and no provisions herein shall be construed to diminish, lessen, limit, share, or divide the authority of DHHS or the Secretary of DHHS to so act.

c. Should DMA for any reason terminate their contract with an LME operating a PIHP under the terms of this contract, DMHDDSAS will automatically terminate this Contract immediately for cause and the LME shall work with DMHDDSAS and DMA to provide Medicaid benefits to Enrollees and state funded individuals receiving services through other options available in the State.

23.0 Secretary's Authority Undiminished

Certain functions delegated to the LME pursuant to this Contract are the duty and responsibility of DHHS as the single state agency responsible for the administration of the North Carolina Medicaid program and as the grantee of federal block grant funds such as the Mental Health Block Grant, the Substance Abuse Prevention and Treatment Block Grant and the Social Services Block Grant. The parties understand and agree that nothing in this Contract shall be construed to diminish, lessen, limit, share, or divide the authority of the Secretary of DHHS to perform any of the duties assigned to the DHHS or its Secretary by the North Carolina General Statutes, the State Medicaid Plan, the Medicaid laws and regulations, the terms and conditions of the block grants and their applicable laws and regulations or other federal laws and regulations regarding any federal funding which is used by DHHS to reimburse the LME for any of its contractual duties

24.0 Originals

In witness whereof, the LME and DMHDDSAS have executed this Agreement in duplicate originals, one of which is retained by each of the parties.

25.0 Notifications

The persons named below shall be the persons to whom notices provided for in this Contract shall be given. Either party may change the person to whom notice shall be given. All notices shall be deemed received only when they are actually received.

For the Division:

Steven Jordan, DMHDDSAS Director
325 N. Salisbury St
3001 Mail Service Center
Raleigh, NC 27699-3001
Phone (919) 733-7011 Fax (919) 508-0951

For the LME:

NAME, POSTION
LME NAME
STREET ADDRESS
CITY, STATE, ZIP CODE + FOUR
Phone: Fax:

26.0 Signature Warranty

Each individual signing below warrants that he or she is duly authorized by the party to sign this Contract and to bind the party to the terms and conditions of this Contract.

BY: _____ Witness: _____
Name

TITLE: _____

LME: _____

DATE: _____

Division of Mental Health, Developmental Disabilities, Substance Abuse Services

BY: _____
Division Director

DATE: _____

ATTACHMENT I
PURPOSE, MISSION, VISION AND SCOPE OF WORK

PURPOSE:
The purpose of the waiver expansion is to actualize DHHS and DMHDDSAS's Mission and Vision for North Carolina.

DHHS MISSION:

The mission of the Department of Health and Human Services is to provide efficient services that enhance the quality of life of North Carolina individuals and families so that they have opportunities for healthier and safer lives resulting ultimately in the achievement of economic and personal independence.

DMHDDSAS MISSION:

North Carolina shall endeavor to provide people with, or at risk of, mental illness, developmental disabilities and substance abuse problems and their families the necessary prevention, intervention, treatment, services and supports they need to live successfully in communities of their choice.

VISION:

Responsible change to achieve easy access, better quality and cost-effectiveness:

1. Public and social policy toward people with disabilities shall be respectful, fair and recognize the need to assist all that need help.

2. The state's service system for persons with mental illness, developmental disabilities and substance abuse problems shall have adequate, stable funding.

3. System elements shall be seamless: consumers, families, policymakers, advocates and qualified Providers shall unite in a common approach that emphasizes support, education/training, rehabilitation and recovery.

4. All human service agencies that serve people with mental health, developmental disabilities, and/or substance abuse problems shall work together to enable consumers to live successfully in their communities.

5. Within this vision, Consumers shall have:

    a. Meaningful input into the design and planning of the services system;

    b. Information about services, how to access them and how to voice grievances;

    c. Opportunities for employment in the system;

d. Easy, immediate access to appropriate services;

e. Educational, employment or vocational experiences that encourage individual growth, personal responsibility and enjoyment of life;

f. Safe and humane living conditions in communities of their choice;

g. Reduced involvement with the justice system;

h. Services that prevent and resolve crises;

i. Opportunities to participate in community life, to pursue relationship with others and to make choices that enhance their productivity, well being and quality of life;

j. Satisfaction with the quality and quantity of services; and

k. Access to an orderly, fair and timely system of arbitration and resolution.

6. Within this vision, Providers and Care Managers shall have:

a. The opportunity to participate in the development of a state system that clearly identifies target groups, core functions and essential service components;

b. Access to an orderly, fair, and timely system of arbitration and resolution;

c. Documentation and reimbursement systems that are clear, that accurately estimate costs associated with services and outcomes provided, and that contain only those elements necessary to substantiate specific outcomes required; and

d. Training in Services that are provided.

The values of Recovery, Self Determination, Person Centered Planning and Consumer and Family driven services are the basis for this waiver expansion, and are in the North Carolina State Plan.

7. GOALS OF THE EXPANSION:

a To provide a funding strategy that includes single management of all resources through a public local system manager in order to provide for coordination and blending of funding resources; collaboration with out- of-system resources; appropriate and accountable distribution of resources; and allocation of the most resources to the people with the greatest disabilities;

b To transition the local system toward treatment with effective practices that result in real life recovery outcomes for people with disabilities;

c To promote community acceptance and inclusion of people with disabilities, to provide outreach to people in need of services, to promote and ensure accommodation of cultural values in services and supports, and to serve people in their local communities whenever possible;

d To provide for easy access to the system of care;

e To ensure quality management that focuses on health and safety, protection of rights, achievement of outcomes, accountability, and that strives to both monitor and continually improve the system of care;

f To empower consumers and families to set their own priorities, take reasonable risks, participate in system management, and to shape the system through their choices of services and Providers;

g To empower the LME-MCO to build local partnerships with the people who depend on the system for services and supports, with community stakeholders and with the providers of service; and

h To demonstrate an interactive, mutually supportive, and collaborative partnership between the State Agencies and the LME-MCO in the implementation of public policy at the local level and realization of the state's goals of system reform delineated in the Blueprint for Change.

The LME-MCO, as a public local system manager and implementer of the State's public policy, has developed the infrastructure and functional capacity to direct, coordinate, manage, and ensure accountability in this transformation of the local system and to attain the goals established in this Contract.

SCOPE OF WORK

The LME shall perform all Local Management Entity (LME) functions in accordance with G.S. § 122C-115.4 and DHHS requirements. This scope of work is contingent upon available funding. In the event that funding is reduced, the scope of work will be reviewed within thirty (30) days of such funding reduction. The functions include:

(1) General Administration and Governance;
(2) Business Management and Accounting;
(3) Information Management Analysis and Reporting;
(4) Claims Processing;
(5) Provider Relations;
(6) Access, Screening, Triage and Referral;
(7) Service Management
(8) Consumer Affairs and Customer Service;
(9) Quality Management

1.0 General Administration and Governance

1.1 Area Board and Consumer and Family Advisory Committee (CFAC) Relationship

At the request of either the CFAC or the governing board of the area authority or county program, the CFAC and the governing board shall execute an agreement that identifies the roles and responsibilities of each party, channels of communication between the parties, and a process for resolving disputes between the parties.

1.2 Area Board Meetings

The LME shall ensure that the Board meets the composition requirements of G.S. § 122C-118.1 and shall meet at least six (6) times per year. The LME shall provide an annual training and sufficient support to ensure that the Board actively reviews regular reports on finances, local performance, service utilization, customer service, unmet local service needs and provider capacity. Unless delineated elsewhere, each LME shall define training needs.

1.3 Consumer and Family Advisory Committee (CFAC) Meetings

The LME shall provide sufficient financial and administrative support to ensure that the CFAC shall meet the composition requirements of G.S. § 122C-170 and shall meet at least six (6) times per year. The LME shall provide sufficient training on the LME business plan, budget, and other topics to support the CFAC's review of regular reports on finances, local performance, and customer service on a regular basis.

1.4 Area Director Evaluation

The Area Board shall ensure that its annual evaluation of the Area Director includes an evaluation of the criteria established by the NC Secretary of DHHS in Communication Bulletin # 20, dated June 1, 2004 which referenced 122C-121(b).

1.5 Capacity and Competency

The LME shall have an administrative and organizational structure adequate to perform the functions required under this contract. The LME shall employ qualified personnel sufficient to carry out the requirements of this contract. This includes ensuring sufficient numbers of staff meeting the CMS definition of Skilled Professional Medical Personnel (SPMP) and clinical staff competent in all three disability areas. The LME shall ensure that all staff persons have the training, education, experience, licensing or certification appropriate to their position and responsibilities.

1.6 Conflict of Interest

The term "conflict of interest" refers to situations in which financial or other personal considerations may adversely affect, or have the appearance of adversely affecting, an individual's professional judgment in performing any activity or duty in connection with this contract. The LME operating a PIHP shall not contract with, or make any referral of a recipient to, any provider entity in which the LME or any member of the LME staff or a board member is an investor.

Any advisory committees, employees, volunteers, agents and contractors of the LME shall refrain from participation in clinical or administrative activities or decisions in which there is or may be a conflict of interest.

The LME, operating a PIHP, shall not serve as legal guardian for any recipient of either enrollee of Medicaid or State Funded mental health, developmental disabilities or substance abuse services.

2.0 Business Management and Accounting

2.1 Management of State Service Funds

The LME shall establish timely processes and procedures that ensure that funds are available to reimburse providers for legitimately authorized, provided, and billed services. This includes estimating the percentage of authorized services that will be delivered so that only those funds that will be spent are encumbered. The LME, LME NAME, shall use the approved contract for purchasing services from providers and shall comply with the statewide claims processing requirements.

2.2 Financial Records

In addition to meeting all applicable state and federal statutory and regulatory requirements, the LME shall comply with applicable Generally Accepted Accounting Principles and GS 159, as appropriate. The LME shall maintain up-to-date and accurate automated accounting system. The accounting system should be in such a manner as to produce accounting records for accounts payable and receivable by related account codes. The LME shall submit to its Board a monthly finance report that includes an income statement and except for single counties a balance sheet. The LME shall submit other financial information to its Board, the boards of county commissioners, county managers/finance officers, CFAC and DHHS as set forth in G.S. 122C.

2.3 Contracting for Service Delivery

The LME, LME NAME, shall use the contract templates approved by the Department of Health and Human Services G.S. 122C-142(a) upon approval from the Secretary when contracting for state and non-Medicaid federal funded services. All provider contracts must specify that the provider shall conform to the provisions of this Contract and comply with all applicable federal and state laws, regulations, and policies. All provider contracts shall be in writing. The LME shall retain one fully executed original of each provider contract. The LME shall make provider contracts available for the Department's inspection and copying within two working days after it receives the Department's written request. The LME shall not contract with any provider that has been debarred, suspended terminated or otherwise lawfully prohibited from participation in any federal or state government procurement activity. The LME shall only contract with not-for-profit organizations when using federal block grant funds. Pursuant to Attachment III, 3.0, state and non-Medicaid funds may only be used to purchase services that conform to state-approved service definitions.

3.0 Information Management

3.1 Information Technology Infrastructure

The LME must have the ability to send files in standard Electronic Data Interchange (EDI) format. All electronic Protected Health Information (PHI) must be encrypted. The LME's IT infrastructure shall be fully compliant with the Administrative Simplification Provisions, Sections 261 through 264, of the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191; the HIPAA Privacy and Security regulations in 45 CFR Parts 160, 162, and 164; and the regulations governing the Confidentiality of Alcohol and Drug Abuse Patient Records in 42 CFR Part 2. The LME must have an internet connection and browser capabilities as well as file sharing capabilities with File Transfer Protocol (FTP) Software.

3.2 Federal Health Information Technology Interoperability Standards

In the implementation of electronic health record technology and throughout all of their information technology applications used in the support of an electronic health record, the LMEs shall monitor and adhere to the Federal health information technology interoperability standards that will be specified as a result of the American Recovery and Reinvestment Act of 2009 (http://frwebgate.access.gpo.gov/cgibin/getdoc.cgi?dbname=111_cong_bills&docid=f:h1enr.pdf) specifically, but not exclusively Title XIII - Health Information Technology (short title "Health Information Technology for Economic and Clinical Health Act" or the "HITECH Act")."

3.3 Consumer Information

The LME shall manage providers and ensure that providers submit to the LME in timely manner information on individuals requesting and/or receiving services through federal, state and county funds. The LME shall maintain accurate and up-to-date consumer information and eligibility records in a manner which protects the privacy rights of consumers. The LME shall request and record consumer social security numbers only when it is imperative for the performance of that agency's duties and responsibilities as prescribed by law (G.S. § 132-1.10) The LME shall submit timely consumer screening, admissions, updates, eligibility, and episode completion information to DHHS, as specified in DHHS policy, including additions, deletions, and changes in consumer status. The LME shall ensure that providers submit required information, including Person Centered Plans, NC-SNAP data, NC-TOPPS data, incident and death reports, and MHSIP Consumer Surveys and National Core Indicators information, as appropriate.

3.4 Analysis of Data

The LME shall analyze consumer access, and process service authorization and claims payment data to inform management decision-making in areas including: identification of high cost/high need consumers; provider billing patterns and trends; utilization of various services in the service array; identification of gaps in the service array; consumer movement among providers, continuity of care and personal consumer outcomes.

The LME shall also partner with CCNC in sharing of information to inform management decision making in areas of consumer access, initiation, engagement, retention, continuity of care, and other areas approved in Attachment VI CCNC Informatics Agreement.

3.5 Website

The LME shall maintain a web site on the Internet that includes current and accurate information on how consumers and families may access services in the catchment area. The home page shall identify a toll free access number and a toll free customer service number within the catchment area.

3.6 Encounter Data:

When the MMIS is revised to accept and process encounter data, the PIHP shall submit to DMA an electronic record of every encounter between a network Provider and an Enrollee within fifteen (15) days of the close of the month in which the specific encounter occurred, was paid for, or was processed, whichever is later, but no later than 180 days from the encounter date. DMA shall conduct validation studies of encounter data, testing for timeliness, accuracy and completeness. The PIHP shall report all encounters that occur up to the date of the termination of this Contract. The PIHP is subject to sanctions for late or incomplete submissions in accordance with the terms of SOW Section 13. If the Contract terminates while payments are being withheld by DMA due to inaccurate or late reporting of encounter data, DMA shall continue the withhold until the PIHP reports all encounter data according to Contract Attachment W, Financial Reporting Requirements.

Until the MMIS is revised to accept and process encounter data, the PIHP shall submit electronic records of encounters to DMA -- or contractors acting on DMA's behalf -- on an as-needed basis for the purposes of rate-setting, quality assurance, waiver amendments, renewals, mandatory external review activities, and other activities deemed necessary by DMA. Encounter data submitted to DMA from the PIHP must be signed by the PIHP's Chief Financial Officer and must contain a statement certifying the accuracy of the data.

All encounter data submitted by the PIHP to DMA, the MMIS or a contractor acting on DMA's behalf shall include the Medicaid provider number of the Network Provider IF the Network Provider is enrolled in DMA's fee-for-service Medicaid program.

4.0 Claims Processing

4.1 Provider Billings Made Through the LME

The LME shall honor provider billing for State funds that are filed in accordance with the LME's contract with the provider. If the provider bills within Ninety (90) days of providing a service, the LME will pay claims in accordance with the Division prompt pay requirements set forth as follows: within eighteen (18) calendar days after the LME receives a claim from a provider, the LME shall either: (a) approve payment of the claim, (b) deny the claim, or (c) determine that additional information is required for making an approval or denial. If the LME approves the payment, the claim shall be paid within 30 calendar days after making approval.

The LME shall disallow claims in the event and to the extent the claim is incomplete, does not conform to the applicable service authorization, or is otherwise incorrect. Any disallowed shall be returned to the provider with an explanation for the disallowance. The LME shall allow providers to re-submit a disallowed billing for re-consideration, so long as the re-submission occurs within the general claims filing timeframes outlined above. The LME shall cooperate with its contract providers in the prompt reconciliation of disallowed billings.

All payments for services to providers shall be provisional and subject to review and audit for their conformity with Division requirements and those of any applicable subcontract.

4.2 First and Third Party Payments

The LME shall work with its providers to pursue all applicable first and third party payments for services in order to maximize the usage of public resources. In the event that a consumer has third party coverage or is determined to be able to pay any portion of the cost of services in accordance with G.S. § 122C-146, the LME shall coordinate benefits so that costs for services otherwise payable by DHHS are avoided or recovered from a liable first or third party payer. The LME's claims system shall include appropriate edits for coordination of benefits and third party liability.

The LME or its provider contractors may retain any first or third party revenue obtained if both of the following conditions exist:

(1) Total collections received do not exceed the total cost of services for all persons served, and
(2) State and federal law does not require the state to recover first and third party payments from the LME.

The LME shall obtain, or require its contracted providers to obtain, all relevant payer information from each consumer to be served, his or her guardian and/or family. This information shall be collected at the consumer's first encounter with the LME or its contract provider, except in emergency or crisis services and no later than the submission of the first claim to service. The LME shall provide available information to each provider involved with the consumer and require the provider to collect the remaining information, if applicable. The LME shall require providers to report first and third party collections on individual claims.

5.0 Provider Relations and Support

5.1 Assessment of Adequacy of the Provider Community

Under the terms of this Contract, the Division delegates the LME the authority to develop and manage a qualified provider network, including certified CABHA agencies, in accordance with community needs including enrollment, un-enrollment, and certification of providers including assessment of qualifications and competencies in accordance with applicable state and federal rules, standards and the provider qualifications established by the LME and deemed necessary for the effective provision of quality services.

The LME shall complete a new provider capacity assessment and update completed progress by the third quarter. The assessment shall take into consideration the population in the catchment area, identified gaps in the service array including services for low incidence populations such as TBI, perceived barriers to services access, and

the number and variety of age/disability providers. The assessment shall take into consideration the need and capacity for certified CABHA agencies within the LME catchment area specially for those services specifically tied to CABHAs. The assessment shall include input from consumers, families, community stakeholders, and CFAC. In evaluating the adequacy of the provider community the LME shall consider issues such as the cultural and linguistic competency of existing providers and provisions of evidence based practices and treatments and the availability of community services to address housing and employment issues. The assessment shall also measure the availability of providers willing to participate in community emergency response efforts, such as providing services in temporary housing shelters in the event of a natural disaster which triggers an evacuation. The LME shall report the results of the annual assessment using a standardized format to the DMHDDSAS, the Board and CFAC and provide quarterly updates to the Board and CFAC. The LME shall demonstrate that it is engaged in development efforts to address service gaps identified in the assessment.

In addition, the LME shall assess community need and provider capacity for children's services within the LME catchment area. The LME shall contract with a sufficient number of service providers to ensure that children receive services in settings which are more likely to maintain or develop positive family and community connections.

5.2 Choice of Providers and Treatment

The LME shall ensure that, except for services with very limited usage or services for which there is not sufficient demand or funding to support more than one provider, consumer have a choice of service provider consistent with CMS waiver requirements, provided however that the LME is vested with the responsibility under this contract to decide the number of providers and which providers shall become members of the LME's provider network. The LME will endeavor to ensure consumers have a choice of evidence based practices and treatments.

The LME will work with the DMHDDSAS and providers to offer new service practices including Evidence Based Practices that consist of those clinical and administrative practices that have been proven to consistently produce specific, intended results and promising best practices that enrich the lives of individuals receiving mh/dd/sa services.

5.3 Provider Manual

The LME shall develop, maintain, and distribute a Provider manual that informs providers and potential providers of the LME and DMHDDSAS processes, procedures, deadlines, and other information about the LME. This distribution may occur by making the manual available electronically on its website. DMA shall have the right to review and approve the Provider manual prior to its release. The manual shall contain, or refer providers to, consumer rights information, service definitions, documentation and billing requirements, medical records requirements, consumer confidentiality and HIPAA privacy protections, etc. The manual shall be updated at least annually. At a minimum, the Provider manual shall cover the areas listed below.

a. Purpose and mission;

b. Treatment Philosophy and Community Standards of Practice;

c. Behavioral health Provider Network requirements, including: nondiscrimination, on-call coverage, credentialing, re-credentialing, access requirements, no-reject requirements, notification of changes in address, licensure requirements, insurance requirements, and required availability;

d. Appointment access standards;

e. Authorization, utilization review, and care management requirements;

f. Care Coordination and discharge planning requirements;

g. Documentation requirements, as specified in APSM 45-2 or as required by the Physician's Services Manual;

h. Provider appeals process;

i. Complaint investigation and resolution procedures;

j. Performance improvement procedures, including at a minimum: Recipient satisfaction surveys; Provider satisfaction surveys; clinical studies; incident reporting; and outcomes requirements;

k. Compensation and claims processing requirements, including required electronic formats, mandated timelines, and coordination of benefits requirements; and

l. Patient rights and responsibilities.

The LME shall provide to Providers any and all training and technical assistance it deems necessary regarding administrative and clinical procedures and requirements, as well as clinical practices.

5.4 Enrollment of Providers

5.4.1. Credentialing:

The LME shall have written policies and procedures for provider credentialing, re-credentialing, initial qualifications, accreditation, and re-accreditation, in accordance with community standards in care and service provision, and the rules and standards of the Division. The LME will implement its policies and procedures for credentialing, recredentialing, provider qualification, accreditation and re-accreditation with providers with which it has signed contracts or participation agreements. Such providers fall under its scope of authority and action under the terms of this Contract and for all services provided with funding from DMH/DD/SAS. The LME shall maintain credentialing, qualification and accreditation records that demonstrate compliance with its policies and

procedures. These records shall be made available to DMH/DD/SAS during business hours. The credentialing, recredentialing, accreditation, and reaccreditation criteria must be consistent with State and Federal regulations governing the professional areas for those providers. The LME shall monitor licensed, certified, registered or accredited providers for continued compliance with these criteria.

5.4.2 Enrollment:

The LME may deny enrollment of providers in its network based on determination of qualification or need for the type of service offered by the provider. If the LME declines to enroll individual providers or provider agencies within its Network, it must give the affected providers written notice of the reason for its decision. If the LME has determined that it has sufficient numbers of providers to meet the needs of its consumers, it is not obligated to conduct qualification (endorsement), credentialing or accreditation review of providers requesting to join its network. The LME shall have written policies and procedures for the determination of need, selection and retention of Network Providers.

5.4.3 Provider Selections:

The LME is not required to contract with providers beyond the number necessary to meet the needs of its enrollees.

The LME may use different reimbursement amounts for different specialties or for different practitioners in the same specialty; and will establish measures that are designed to maintain quality of services, control cost consistent with its responsibilities to enrollees.

The LME will monitor provider performance and will utilize information obtained from the standardized monitoring tools and other monitoring activities, Utilization Management Program on over- and – under-utilization, service effectiveness, submission of required data and reports, Quality Management Program that establishes quality of care outcome measures and thresholds, Accreditation Outcomes, consumer incidents Grievance, Appeal, Complaint logs, Enrollee satisfaction surveys, and other quality improvement information in decisions to re-accredit, re-credential and re-enroll providers for its network. The LME shall provide training and technical assistance it deems necessary and practical to providers regarding administrative and clinical procedures, and requirements, as well as clinical practices.

The LME shall develop, maintain, and distribute a provider manual as identified in Section 5.3 that provides information and education to providers about providing services in the LME NAME Network. This distribution may occur by making the manual available electronically and on its website website and giving providers notification of revisions.
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The LME shall publish a manual for consumers that identify enrolled providers, services provided, and populations served.

5.5 Provider Monitoring

The LME shall monitor non-Medicaid funded, Medicaid, and Health Choice providers in accordance with DHHS policy and applicable statutes. Such monitoring shall not duplicate regulatory authority or functions of agencies of the Department. Monitoring shall include, but is not limited to, determining providers' progress in achieving national accreditation, compliance with federal and state confidentiality laws, compliance all requirements and restrictions of the SAPTBG, CMHSBG, SSBG, and their accompanying state MOE requirements, PATH formula grant, SPF-SIG, SDFSCA, and all other applicable federal grant program funds requirements and restrictions on the expenditure of funds, first responder capacity and quality, compliance with data submission requirements, consumer rights protection, incident reporting and rights protection requirements, meeting defined quality criteria, compliance with regulatory and licensure board requirements for qualifications of staff, adherence to evidence based practices in the delivery of services and compliance with DHHS documentation requirements.

The LME shall assure a stable and high quality provider system in the LME's catchment area. The LME shall monitor providers to ensure that they remain in compliance with endorsement criteria following their endorsement. The LME shall utilize the Frequency and Extent of Monitoring (FEM) tool, to determine a confidence level and consequent monitoring frequency for providers in their catchment area or other requirements as outlined and adopted by the Affordable Care Act (ACA) rules April 1, 2011. Provider monitoring based on FEM scores shall occur via the DMH/DD/SAS Provider Monitoring Tool for Local Management Entities.

In addition to ongoing monitoring responsibilities for the providers in the LME catchment area, it is a function of the LME to ensure a stable and high quality provider system, and to assure the Division that providers in the LME catchment area are in substantial compliance with the requirements of the service(s) they are enrolled to deliver.
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5.6 Technical Assistance to Providers

The LME shall render technical assistance to providers on LME-specific policies, procedures, and requirements Medicaid-and Health Choice specific policies, procedures, and communications and Division policies and communications. The LME shall train providers to develop and implement appropriate crisis response systems for consumers who access emergency services. The LME shall help providers develop or improve their quality improvement activities. The LME shall help providers locate appropriate sources of technical assistance or training if the LME is unable to provide the needed assistance or training.

In order to foster a stable and high quality provider system, the LME shall offer technical assistance to providers to assist them in navigating the MH/DD/SA system or LME protocols. The LME shall provide guidance regarding the requirements and expectations of the State MH/DD/SA system, NC Health Choice, and LME protocols. The LME may offer any technical assistance that serves the purpose of assuring an

adequate supply of providers for consumers in the LME's catchment area. The LME is not required to provide any technical assistance that would be considered a normal operational procedure of a service provider. The LME shall not be required to provide technical assistance to a provider who has not assimilated previous technical assistance into its provider infrastructure.

5.7 Provider Complaints

Pursuant to G.S. 122C-151.3, the LME shall establish written procedures for local level informal dispute resolution with providers. Provider disputes may be appealed to the LME Appeals Panel. The LME shall respond to complaints from providers in a timely manner.

6.0 Access, Screening, Triage and Referral

6.1 Telephonic Access

The LME shall provide toll free access lines to its entire catchment area. The toll free lines shall be widely disseminated throughout the catchment area through written and broadcast public service announcements, and by including the number prominently in all LME publications and on the LME website.

The LME shall ensure that the toll-free access line is staffed by individuals that meet the definition of qualified professionals. Licensed clinicians that meet the Skilled Professional Medical Personnel (SPMP) qualifications set forth in 42 CFR 432.50(d) will be on site for consultation. A 24/7/365 toll free access line will be available.

The LME shall host a direct, toll free TTY access line. The LME shall utilize a Relay Service (Telephone or Video) when telephonic assistance from a Relay Service is requested by a consumer.

Foreign language interpretation shall be available at no cost to the caller.

When calling the access line, the consumer shall not be required to navigate an automated calling menu.

The LME telephonic access line staff and/or emergency response staff shall have electronic access to the crisis plans if submitted by providers, of consumers currently actively receiving services in their home LME's catchment area in order to expedite crisis services. The LME staff shall have the ability to schedule appointments within 24 hours of initial contact.

6.2 Screening

The LME shall ensure that consumers who have not received any service in the past 60 days and who present in person or who contact the toll free access line are screened. The LME shall ensure that all of the elements specified in the State's uniform screening tool are collected for persons screened by the LME or its providers and those elements

are captured in the LME's electronic reporting system and reported to CDW as required by the CDW Reporting Requirements and Data Dictionary. Screening shall include a preliminary determination of target population eligibility. Screening shall also include an assessment of the urgency of the consumer's needs. The LME shall ensure that entities contracted to conduct screening, triage and referral activities for the LME use and submit the information on the LME's electronic reporting system in a timely manner. Persons with substance use or abuse concerns shall be identified and triaged as persons with either Emergent or Urgent need.

6.3 Triage and Referral

The LME shall refer consumers to the providers of their choice, subject to the following access standards:

(1) Consumers experiencing an emergency (immediate need) are able to access emergency services through the LME and receive face to face services within two hours of the request for service.

(2) If the consumer need does not constitute an emergent (immediate) situation, but is nonetheless urgent (an urgent need is a consumer who presents moderate risk or incapacitation in one or more areas of safety or physical, cognitive, or behavioral functioning related to mh/dd/sa problems) rather than routine, the LME shall refer consumers to a provider capable of delivering face-to-face services within 48 hours of the request for services.

The LME shall refer consumers with a routine need (a routine consumer presents with mild risk or incapacitation in one or more areas of safety or physical, cognitive, or behavioral functioning related to mh/dd/sa problems) for service to a provider capable of delivering face-to-face services within 10 business days (calculated as 14 calendar days) of the request for services.

The LMEs shall report quarterly to the DMHDDSAS a summary of consumers screened, triaged and referred, using the approved DMHDDSAS form and definitions.

6.4 Access to State Operated Facilities

A single entry mechanism shall be in place for admission to and discharge from State operated institutions.

The LME Director shall serve as the designee of the Director of the Division of Mental Health, Developmental Disabilities and Substance Abuse Services in approving admission to State psychiatric hospitals in accordance with G.S. § 122C-261(f)(4). In so doing, the LME Director shall ensure that every effort has been made to identify an appropriate alternative treatment location prior to approving the admission to the State psychiatric hospital.

7.0 Service Management

7.1 Utilization Management

The LME shall evaluate the medical necessity, clinical appropriateness, efficiency, and effectiveness of health care services for consumers receiving or requesting services against established guidelines and criteria.

The LME shall have sufficient numbers of experienced and qualified utilization, care management, and care coordination staff to meet the terms of this Contract. Utilization managers and care managers for individuals with mental health/substance abuse needs shall be at minimum Master's level Behavioral Health professionals licensed by the State of North Carolina with a minimum of two years post-Master's experience in a clinical setting with the population served. Utilization managers, care managers, care coordination staff for developmental disabilities services shall be completed by a Qualified Professional in the area of Developmental Disabilities as specified in 42 CFR 483.430 (a) and N.C. Gen. Stat. §122C-3;

7.1.1 Benefit Design

The LME shall adopt and publish during the term of this contract the benefit plan for target population consumers that define the services that individuals in each target population may expect to receive. The benefit plan shall be flexible to maximize the services that consumers may receive while ensuring the LME delivers services within available funding. Nothing in this contract shall be construed or interpreted as creating an entitlement to state funded services.

7.1.2 Crisis Services

The LME shall provide or arrange for a 24/7/365 crisis response service as mandated by G.S. § 122C-117(a)(14). The LME shall have a full array of crisis services within its provider network which supports consumers and the community. The LME shall build a community collaborative of crisis/emergency stakeholders that engage in and support crisis prevention, crisis stabilization, and engagement of individuals into services after a crisis event promoting hope, self-direction, recovery, and wellness using community services and natural supports.

7.1.3 Person Centered Plan Review

The LME shall review and approve Person Centered Plans (PCP) for consumers receiving services that require PCPs. This review shall assess the:

(1) Providers' use and implementation of the Records Management and Documentation Manual, including evidence of medical necessity, appropriate and measurable goals, target dates, necessary signatures,
(2) Compliance with DMHDDSAS policies, procedures, and guidelines;
(3) Inclusion of a crisis plan;

(4) Inclusion of basic medical care such as: linkage to a medical home.

The LME shall ensure that information regarding the quality and completeness of the plans produced by individual providers is communicated to LME staff responsible for providing technical assistance to providers.

7.1.4 Service Authorization

The LME shall authorize services based upon a properly completed PCP/Service Plan (as required) and in accordance with the LME's benefit plan for the consumer's target population. The LME shall respond to properly completed and submitted routine service authorization requests within 14 calendar days; and urgent requests within 24 hours. Service authorizations shall be considered as a commitment to pay (within agreed upon contract limits) when the service is appropriately rendered and documented.

7.1.5 Consumer Notification of LME Service Authorization Decisions

The LME shall notify consumers when services are denied, reduced or terminated by the LME. This notification shall be in accordance with DMHDDSAS processes and procedures and shall advise the consumer of how to exercise their appeal rights regarding the decision.

7.1.6 Post Payment Clinical and Administrative Reviews

The LME shall conduct post-payment reviews of funded services to ensure that services delivered are clinically appropriate and provided in accordance with the NC Administrative Code; the DMH/DD/SAS Records Management and Documentation Manual; the Person-Centered Planning Instruction Manual; DMA Clinical Coverage Policies including service definitions; DMHDDSAS policies and communications; the North Carolina General Statutes and the Federal Code of Regulations. The LME has the authority and responsibility to make clinical and administrative determinations relating to quality and quantity of services rendered by Providers enrolled by the LME.

The LME shall work with the DHHS and DMHDDSAS to identify high risk or high concern areas in which to conduct Post Payment Reviews (PPR) at a level to be mutually agreed upon. As the DMHDDSAS representative, the LME shall develop, maintain and implement an ongoing plan that addresses the scope and conduct of post-payment reviews of non-Medicaid funded services. These post-payment reviews shall include a diverse consumer sample of SAPTBG and CMHSBG funded services and state MOE funded services.

The LME shall have the appropriate licensed clinicians and administrative staff involved in clinical decision making available upon request to participate in any appeal process. The LME shall have the appropriate licensed clinicians or administrative staff available upon request to participate with the department in developing ongoing review of all enhanced services.

LME's are required to conduct an investigation and take appropriate action in response to Quality of Care and Health and Safety issues reported to the LME by DMH when

DMH receives these concerns from a State regulatory or enforcement agency, an agency of DHHS, an agency of the federal government, or a national accreditation organization as a result of any findings and reports back to the State.

7.1.7 Wait List Waiver Service Requests

The LME shall maintain a list of consumers wishing to be considered for participation in Waiver. The list shall be prioritized based upon each consumer's acuity of need. The LME shall notify case managers of the most acutely in-need consumers in order to process the eligibility determination requests. The LME shall report quarterly information about persons on the wait list to DMHDDSAS in the specified format.

7.2 Care Coordination

7.2.1 Care Coordination for Consumers without a Clinical Home

The LME shall provide care coordination services for individuals who are being discharged from state facilities, hospitals, or emergency services that do not have a connection with a clinical home provider. This includes assigning care coordinators to function as institution liaisons participating on-site in discharge planning for consumers being discharged from state hospitals and alcohol and drug abuse treatment centers and other important community partner providers and agencies continuing to work with the consumer and CCNC / medical home until the consumer is connected to a clinical home provider. The LME has the responsibility to ensure that staff is available for participation at the annual Plan of Care meetings for consumers from their catchment area who reside in a Developmental Center and are appropriate for community placement. The LME shall ensure that individuals who are being discharged from DHHS state facilities and community inpatient hospital services, detox facilities, and facility based crisis centers are seen by a community provider within 7 calendar days of discharge. The LME shall ensure that consumers who do not attend scheduled appointments are contacted to reschedule services within 5 calendar days.

7.2.2 Care Coordination for High Cost/High Risk Consumers

The LME shall identify and provide care coordination services for consumers having high cost and/or high need. Pursuant to G.S. §122C-115.4 (1),(2), until such time as the Commission adopts another definition by rule, a "high risk consumer" means a person who has been assessed as needing emergent crisis services three or more times in the previous 12 months. Pursuant to G.S. §122C-115.4 (1),(2), until such time as the Commission adopts another definition by rule, a "high cost consumer" means a person whose treatment plan is expected to incur costs in the top twenty percent (20%) of expenditures for all consumers in a age/disability group." This includes involvement in Person Centered Planning, facilitating appropriate connections to primary health care services through Community Care, the Health Department, or other physical healthcare providers. For children, this responsibility includes participation in Child and Family Teams.

7.2.2 (a) Care Management as an MCO - LME:

MCO shall manage Enrollee care and for State funded individuals by performing, at a minimum, the following Care Management functions:

a. The MCO shall be available 24 hours per day, seven days per week, to perform telephone assessments and crisis intervention;

b. MCO shall determine which Behavioral Health Services are Medically Necessary for each individual;

c. MCO shall perform Quality Monitoring of the Behavioral Health Services provided to individuals by Network Providers;

d. MCO shall coordinate and monitor Behavioral Health hospital and institutional admissions and discharges, including discharge planning;

e. MCO shall ensure the coordination of care with each individuals's primary care Provider/CCNC physician;

f. MCO shall provide follow-up activities to high risk individuals who do not appear for scheduled appointments; to individuals for whom a crisis service has been provided as the first service, in order to facilitate engagement with ongoing care; and to individuals discharged from 24 hour care;

g. MCO shall ensure that each individual's privacy is protected in accordance with State and federal law.

Care Management for Enrollees with Special Health Care Needs:

h. The MCO shall identify individuals who have special health care needs. Individuals with special health care needs are defined as:

Intellectual and/or Developmental Disabilities:

Individuals who are functionally eligible for, but not enrolled in, the Innovations waiver, who are not living in an ICF-MR facility; **OR**

Individuals with an intellectual or developmental disability diagnosis who are currently, or have been within the past 30 days, in a facility operated by the Department of Correction (DOC) or the Department of Juvenile Justice and Delinquency Prevention (DJJDP) for whom the LME has received notification of discharge.

Child Mental Health:

Children who have a diagnosis within the diagnostic ranges defined below:

293-297.99	298.8-298.9	300-300.99	302-302.6	302.8-302.9
307-	308.3	309.81	311-312.99	313.81

307.99				
313.89	995.5-995.59		V61.21	

AND

Current CALOCUS Level of VI, **OR**

who are currently, or have been within the past 30 days, in a facility (including a Youth Development Center and Youth Detention Center) operated by the DJJDP or DOC for whom the LME has received notification of discharge.

Adult Mental Health:

Adults who have a diagnosis within the diagnostic ranges of:

295-295.99	296-296.99	298.9	309.81

AND

Current LOCUS Level of VI.

Substance Dependent:

Individuals with a substance dependence diagnosis

AND

Current ASAM PPC Level of III.7 or II.2-D or higher.

Opioid Dependent:

Individuals with an opioid dependence diagnosis AND who have reported to have used drugs by injection within the past 30 days

Co-occurring Diagnoses:

Individuals with both a mental illness diagnosis and a substance abuse diagnosis

AND

current LOCUS/CALOCUS of V or higher, **OR** current ASAM PPC Level of III.5 or higher

a. Individuals with both a mental illness diagnosis and an intellectual or developmental disability diagnosis

   AND

   current LOCUS/CALOCUS of IV or higher

b. Individuals with both an intellectual or developmental disability diagnosis and a substance abuse diagnosis

   AND

   current ASAM PPC Level of III.3 or higher

i. Pursuant to 42 CFR Part 438.208(c), the MCO shall implement mechanisms to assess each Medicaid enrollee and individual identified as

having special health care needs in order to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring ; assessment mechanisms must use appropriate health care professionals.

j. For enrollees with special health care needs who need a course of treatment or regular care monitoring, the MCO shall produce a treatment plan. The treatment plan must meet the following requirements:
    i. Developed by individuals' case manager with enrollee participation, and in consultation with any specialists' care for the enrollee.
        1. All treatment plan development for individuals with mental health and substance needs must be subcontracted by the MCO to a CAHBA or other 'clinical home' enhanced service provider (i.e. ACTT, SAIOP).
        2. All treatment plan development for individuals with intellectual and developmental disabilities must be subcontracted by the MCO to a separate agency that is not-affiliated with the MCO.

    ii. Approved by the MCO in a timely manner (if approval required by plan).

    iii. In accord with any applicable State quality assurance and utilization review standards.

k. If a treatment plan or regular care monitoring is in place for an enrollee with special health care needs, the MCO shall allow enrollees to directly access specialists as appropriate for the enrollee's condition and identified needs.

l. The MCO shall use Quality Monitoring and the Continuous Quality Improvement Process:

    i. To ensure that individual treatment plans (person centered plans) are developed consistent with 42 C.F.R. Part 438.208 and Part 456; and

    ii. To ensure individual participation in the treatment planning process;

7.2.2 (b) Care Management Collaboration with CCNC for unstable Medical and MH/SA/DD Diagnoses

LMEs will form a collaborative relationship with local CCNC networks to manage the Medicaid recipients with unstable medical and MH/SA/DD diagnoses. LMEs will sign data sharing agreements (Attachment XX) with the CCNC Informatics Center. The LME is responsible for Medicaid recipients with Medicaid County of enrollment / eligibility in their catchment areas. The LME and CCNC will develop shared crisis plan for high risk clients. LME care managers shall work closely with primary care providers to insure

coordinated care. LME care managers shall conduct health risk assessments and incorporate into the plan of care

The following represents LME responsibilities for Medicaid Recipients with Unstable MH/SA/DD Diagnoses

Area of Accountability	**LME Responsibility**
Inpatient admit at a State MH Facility	Coordination of MH/DD/SA discharge services
Inpatient admit at any facility for MH/DD/SA diagnoses	Coordination of MH/DD/SA discharge services
Persons assessed as needing emergent crisis services 3 or more times in the previous 12 months • Includes facility-based crisis, mobile crisis, ED, inpatient, state hospital, ADATC • 3 times is defined in episodes, not days. Episode includes all related crisis services from the start of that crisis to the point of resolution (ex; person has mobile crisis contact, than admitted to FBC, then on to state hospital. This = 1 episode)	Care coordination services and patient education around appropriate ED use and patient centered plan to address identified emergent needs.
Patients detained in ED facilities awaiting commitment	Highly contingent upon notification by Hospital and willingness to transfer/discharge
ED Prevention	Plan and Implement ED diversion strategies with other key community partners
Crisis Facilities (identified by facility based crisis code)	Provision of crisis stabilization services and linkage to community services and supports
Pharmacy – appropriate drug therapy for medical and mental health diagnoses	Medication Reconciliation with transition from a facility to another setting i.e. home
CMSA NCQA standards for complex case management	As outlined in the document responsible for the principals of care management and either directly or through partnering agencies the principals that fall under targeted case management

QUADRANT I (LOW PH, LOW BH)	**QUADRANT II (LOW PH, HIGH BH)**
Receive primary care for prevention/early identification of physical and behavioral needs. May have brief encounters w/specialists (physical or behavioral) all providers communicate/link w/Medical Home (could be BHP integrated into medical home) **ALL QUADRANTS:** ❖ **LME and CCNC have the responsibility to provide feedback on all referrals** ❖ **Data sharing for substance abuse treatment must include signed client consent per federal law.**	Should be linked through LME to BHP (including CABHAs) **LME responsibilities:** • Identify BHP for CCNC • link unassigned clients to BHP who qualify • Provide STR, crisis, care management (CM) until linked w/BHP) • Provide consultation for CCNC re: behavioral health conditions that place client at risk • Monitor contracts w/BHPs that require basic medical screening questions, linkages, and communication w/medical home on key clinical information • Insure BHP/LME/Targeted Case Manager (when in place) include: ➢ case management w/medical home ➢ Annual exams/medical needs incorporated into person-centered plan of care (i.e. labs, medications, referral and follow up) and into crisis plan **CCNC responsibilities:** • Referral to BHP if adverse high risk events (i.e. inpatient admission), • If BHP unknown, referral to LME based on local protocol • Referral to BHP **and** LME of pts that meet high risk definition below • Identify for LME/BHP medical home (if unassigned assist w/linking) • Provide consultation for LME/BHP on medical conditions (chronic disease, atypical antipsychotic medications, medical factors that place client at risk) • *If client unwilling to engage w/mental health services* ➢ *Notify PCP and encourage follow up* ➢ *provide info on accessing STR and Mobil crisis services (LME's have handouts)* ➢ *Support/reinforce PCP's plan of care in treatment of common mental health conditions such as depression* ➢ *Implement medical management interventions with a focus on adherence* ➢ *Identify outstanding issues, particularly that impact safety and support system*

	LME Hi-Risk Definition • *MH/DD/SA* inpt. w/out therapist or enhanced MH Service Provider* • *Received emergent crisis services great than or equal 3 episodes in past 12 months*

QUADRANT III (HIGH PH, LOW BH)	QUADRANT IV - HIGH PH AND HIGH BH
Should be linked w/medical home **CCNC responsibilities**: • Identify for LME/BHP medical home (if unassigned assist w/linking) • Provide care management services for clients in medical crisis, until stable and linked w/medical home • Provide consultation for LME/BHP re: medical conditions that place client at risk • PCP/CCNC conducts mental health and substance abuse screenings, linkages, and communicates with BHPs on key clinical information (Regardless if client qualifies for enchased services or requires only brief intervention) • Insure clients receiving CCNC care management have behavioral health needs incorporated into person-centered plan of care (i.e. depression monitoring) and crisis plan **LME responsibilities**: • Referral to PCP if adverse high risk events (i.e. inpatient admission), if PCP is unknown notify CCNC • Referral to both PCP and CCNC for clients meeting high risk (defined below) • Identify for CCNC the BHP (if unassigned, link) • Provide consultation for CCNC/PCP on BH conditions such as evidenced based guidelines, medications, other MH/DD/SA factors that place client at risk ***CCNC Hi-Risk Definition:*** Identified by CCNC and/or LME as high risk as defined by **2 or more chronic conditions**, (physical and/or behavioral) **and is unstable**, as by evidence of 2 or more of the following: • *1 or more inpt. admit w/in past 6 months* • *3 or more ED visits w/in past 6 months* • *8 or more Rx over past month or 24 over past 3 months* • *3 or more outpt. Providers in past 6 months* • *No PCP visit w/in past 12 months* • *2 or more ADL deficits requiring hands on assistance*	Likely require both specialty medical and BH clinical care and is at increased risk. (e.g. pt. w/CHF, DD, COPD, Schizophrenia) **Joint responsibilities:** • Both LME and CCNC retain all responsibilities outlined in Quadrant II and III above, including identification of pts meeting High Risk definitions. • Targeted case manager leads development of comprehensive person centered plan of care and crisis plan that incorporates medical and BH needs • CCNC and LME provide joint care management services or consultation when medically appropriate or indicated. • Targeted case managers insure clients care and crisis plans are coordinated and distributed across the continuum to medical and BH providers. • If client declines targeted case management and is high risk or has an adverse event, CCNC and LME jointly provide care management services until appropriate lead agency is determined based on client need. • Closer collaboration between LME and CCNC to insure clients receive evidenced based behavioral health and physical health care. • CCNC and LME will encourage, support and facilitate communication between PCP and BHP regarding medical management, shared roles in the care and crisis plan, exchange of clinically relevant information, annual exams, coordination of services, case consultation an d problem solving.

• *Additional clinical/social/mental health information supports unstable conditions*	

7.2.3 Deaf Services

If the LME serves as host to a regional deaf services coordinator, the coordinator shall work with all LMEs in the designated region to assure appropriate services are available to consumers who are deaf and hard of hearing. These staff may provide direct services to deaf, hard of hearing and deaf-blind consumers in their home catchment area and may, upon request, provide or facilitate the provision of Diagnostic Assessment, Person Centered Planning, individual/group/family therapy, Telepsychiatry Professional Services, and consultation/technical assistance in their region as their schedules and qualifications permit. It is expected that these staff will provide services to providers in their region at no cost other than transportation (when not included in the Medicaid rate).

The LME shall assure that deaf, hard of hearing or deaf-blind consumers have access to sign language interpreting services when these services are needed (at no cost to the consumer). The LME shall include information related to the availability of sign language interpreting services in marketing materials.

7.2.4 Outpatient Commitment

The LME shall provide care coordination services for its consumers who are under an outpatient commitment order. This includes maintaining up-to-date records on each consumer in the catchment area with an outpatient commitment order including the name or names of their treatment provider(s) and documentation that the LME frequently and routinely contacts the service provider(s) to verify the consumer's compliance with the outpatient commitment order. If the LME determines that the consumer has failed to comply or clearly refuses to comply with all or part of the prescribed treatment, the LME shall report such failure as required by law and take action as necessary to assure the safety of the consumer and the public.

7.2.5 Other Populations in Need

There should be consideration of services to meet the needs of other high need and underserved populations, including members of the military and their families, Traumatic Brain Injury (TBI) individuals and their families, individuals impacted by suicide, violence and trauma, justice offenders, Fetal Alcohol Spectrum Disorders (FASD) individuals and their families, Native Americans and other underserved racial, ethnic, cultural, and linguistic minorities.

7.2.6 Cross Area Service Programs (CASP)

The LME shall ensure the continuing identification and support of Cross Area Service Program (CASP) funding and services as approved by the NC General Assembly and designated in Division allocation letters. The CASP is designated by the Division to receive specialty funding to provide comprehensive regional or statewide services across multiple LMEs. Services are directed through a provider entity designated by the Division and approved by the LME to serve the needs of an identified consumer population. Services are targeted to eligible designated consumers and their families in

an identified region or regions, but available to all eligible consumers and their families statewide as capacity allows.

7.2.7 Professional Liability Insurance

The LME, operating a PIHP, shall maintain professional liability insurance for itself and its professional staff with limits of at least ($1,000,000) per occurrence and at least ($3,000,000) in the aggregate throughout the terms of the contract by the time the contracts are signed.

7.3 Community Collaboration

7.3.1 Community Relationships

The LME shall establish and maintain effective, collaborative working relationships with other public agencies, health care providers, and human services agencies within their catchment area for the benefit of consumers. These include but are not limited to: Departments of Social Services, Local Health Departments, community hospitals, public schools, law enforcement, courts, Juvenile Court Counselors, Community Care Networks and other primary healthcare providers.

7.3.2 Social Marketing Plan

The LME shall develop and implement a plan to engage in public awareness campaigns designed to reduce the stigma attached to disabilities, increase the access and visibility of the LME and service providers in the community, promote prevention, recovery and wellness activities and support and encourage the use of evidence-based practices. The plan shall include a component designed to increase competitive employment opportunities for consumers.

7.3.3 Natural and Community Supports

The LME shall work with other public, faith-based, non-profit organizations and community based recovery and self-help groups to increase the service options available to non-target population individuals and to increase the availability of natural and community supports for all consumers. The LME shall pursue opportunities to increase consumers' access to free or low cost medications, affordable housing, employment and other supports and services.

7.3.4 Emergency Response

The LME shall participate in the development of community response plans and shall work with its providers to ensure adequate capacity to meet the needs of the community in the event of a community-wide disaster or emergency situation.

7.3.5 Development of Housing Opportunities for Consumers

The LME shall work with public housing agencies and private landlords to increase housing opportunities for consumers. The LMEs' Division-funded housing coordinator position shall be dedicated solely to housing activities, work with the Division and DHHS housing staff to increase housing opportunities throughout the region to which the coordinator is assigned, represent the LME as the lead agency on local Housing Support Committees, and act as a contact for the development management in the Targeting Plan over the life of the project to assure that the units are utilized, and that tenants have access to the supportive services that they may need to live successfully in the community.

7.3.6 Community Prevention Services

The LME shall provide leadership, consultation, technical assistance, facilitation, and participation in community-wide efforts to recognize and minimize the occurrence of and impacts from addictive disorders, mental illness, and developmental disabilities.

7.4 System of Care

7.4.1 System of Care Coordinator

The LME shall have at least 1.0 FTE staff member fully dedicated to System of Care Coordination. This person(s) is staff to the Community Collaborative comprised of families, child, youth and family serving agencies and community partners; ensures fidelity to the process of Child and Family Teams for Person-Centered Planning; provides System of Care training and technical assistance to the provider community; and, with local collaboratives, identifies and tracks outcomes to ensure the effectiveness of System of Care efforts.

LME System of Care (SOC) Coordinators will be involved in CFT meetings with Medicaid and Health Choice recipients prior to placement in Level III/IV residential care and PRTF.

7.4.2 School-Based Child and Family Teams (if applicable)

If the LME's catchment area includes one or more school districts participating in the Governor's School-Based Child and Family Teams initiative, the LME shall name one staff clinician to serve as the liaison to those teams.

7.4.3 Community Collaborative

The LME shall support a community collaborative comprised of: (1) family members of a child or youth being served or who was once served in the system (2) child, youth and family serving public and private agencies; and (3) community partners to support System of Care practices and principles of family-driven and youth-guided care,

individualized and community-based services, interagency collaboration, and cultural competence.

8.0 Consumer Affairs and Customer Service

8.1 Supports to CFAC and the Human Rights Committee

The LME shall maintain and provide competent, qualified staff and support to the CFAC and Human Rights Committees to fulfill the functions of these committees in accordance with the requirements of G.S. 122C-170 and G.S. 122C- 64.

8.2 Consumer and Family Outreach and Education

The LME shall provide outreach, education and customer service to consumers and families on issues such as rights protection, complaint processes, advocacy and empowerment opportunities, evidence-based practices and service authorization guidelines. The LME shall publicize that injection drug users and substance-abusing pregnant women have program admission priority.

8.3 Assistance to Consumers

The LME shall provide a Consumer Manual that assists consumers to understand the various parties in the public system, their roles and responsibilities. The LME shall provide assistance to consumers and families in understanding the public delivery system and other public agencies. The LME shall encourage consumer self-advocacy. The LME shall promote the growth of consumer owned and staffed businesses. The LME shall maintain, publish and staff a toll free customer service line during normal business hours. A customer service staff person shall respond to inquiries within one business day.

8.4 Consumer Incidents, Complaints and Appeals

The LME shall respond to complaints and process appeals from consumers in accordance with federal law, state rules and DMHDDSAS processes and procedures. The LME shall report all required information regarding critical incidents, deaths, and consumer complaints and appeals to DHHS in the manner and timeframes outlined in policy and shall report aggregate information on incidents, complaints and appeals to the Board, the human rights committee and CFAC quarterly. If a satisfactory outcome is not reached with the LME, in circumstances where an appeal is appropriate under G.S.143B-147(a)(9) the consumer may also appeal to the MH/DD/SA appeals panel.

9.0 Quality Management

9.1 Identification and Remediation of Problems

The LME shall have a process and ensure that their providers have a process for timely identification and response to consumer incidents and stakeholder complaints about

service access or quality, in accordance with federal and state laws, rules and regulations, DMHDDSAS policies and guidelines, and accreditation requirements.
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9.2 Management Reports

The LME shall produce reports referenced in Attachment II 2.0 and use them for planning, decision making, and improvement. The reports shall analyze and summarize patterns and trends related to consumers, providers, and LME operations, including but not limited to:

(1) Consumer trends: incidents, client rights, outcomes, use of state facilities, use of emergency services and hospital emergency departments (as provided by DMHDDSAS), service utilization rates, and perceptions of care;
(2) Local Service System: service capacity, access to care for each population group and underserved groups, barriers to care, local system performance, assessments of provider quality, results of audits and monitoring activities, technical assistance and trainings, and use of evidence-based practices;
(3) LME operations: management of state funds, trends in volume and cost of services per consumer, Screening, Triage, and Referral processes, response to consumer requests for service, complaint response, provider monitoring activities and results, and choice of providers.
(4) Access to primary care: linkage to medical home (Carolina Access) and evidence of a preventative health exam within the past 15 months.

9.3 Consumer Data

The LME shall ensure that its providers collect and submit complete information on consumers, as required by DMHDDSAS policy, in a timely manner. The LME shall provide information and support to its staff, providers, and CFAC members to encourage their use of data collected by the LME and DMHDDSAS for improvement of service quality.

9.4 Quality Improvement

The LME shall establish a quality management committee to identify and address opportunities for improvement of LME operations and the local service system. The committee will have a process for reviewing and incorporating patterns and trends (identified in Section 9.2 above) and input from providers, consumers, family members, and other stakeholders into its decisions. The LME shall conduct annually a minimum of three (3) quality improvement initiatives. Plans, updates and results of these initiatives shall be provided to the local Board and the local CFAC quarterly and to DMHDDSAS, on request..

ATTACHMENT II
Performance Expectations

1.0 Process for Monitoring and Reporting of Local System Quality and Compliance

1.1 Quarterly Report on Performance

The DMHDDSAS shall evaluate the overall performance of the LME system through review of each management function and through statewide measures of service quality, as described in this Attachment. The DMHDDSAS shall calculate and publish quarterly the LME's performance on each indicator listed in Sections 3.0 through 3.7below. This is contingent upon available funding. In the event that funding is reduced, the Performance Expectations will be reviewed within thirty (30) days of such funding reduction.

1.2 Correction of Published Errors

If the LME believes information in the publication to be erroneous, the LME shall contact the designated DMHDDSAS representative (LME Liaison) within 30 days of the publication of data on the above indicators to request a data review. The LME shall provide evidence to support the LME's request and to assist the DMHDDSAS to make a determination concerning the request. Acceptable evidence shall include documentation that information that was submitted to the DMHDDSAS by the end of the month prior to the publication date was erroneously included or excluded.

The DMHDDSAS shall provide a written response to the LME within 30 days of receiving the LME's request. If the DMHDDSAS agrees to correct the error, the DMHDDSAS response shall provide details concerning the error and revision. The DMHDDSAS will publish a notice with the corrected data, when an error is determined to be the responsibility of the DMHDDSAS. If an error that is the responsibility of DMHDDSAS jeopardizes the LME's single stream funding eligibility, the DMHDDSAS will reassess the LME's eligibility based on the corrected data.

2.0 Functional Component Indicators

The DMHDDSAS will monitor the LME's implementation of each management function on an ongoing basis. A fully functioning LME shall have in place all of the components of each management function listed in the table below. The DMHDDSAS shall use the essential components (in bold) to evaluate the LME's performance of each function.

Function	Components
General Administration and Governance	(1) Active Board that meets at least (6) times a year; (Attachment I 1.2) (2) **Active CFAC that meets at least six (6) times a year; (Attachment I, 1.3)** (3) **Qualified CEO that meets required qualifications per NCGS 122C-121(d); (Attachment I, 1.4)** (4) ***Qualified clinical staff in all three disability areas***
Business Management and Accounting	(1) Management of funds to reimburse providers for authorized, delivered, and billed services; (Attachment I, 2.1) (2) Quarterly written reports including a balance sheet provided to the Board and CFAC (Attachment I, 1.2 & 2.2) (3) **Standardized *LME NAME* contracts with providers** (4) Submission of Reports to DMHDDSAS as required;(Contract 10.0 (7) (Attachment I, 2.3)
Information Management	(1) **Fully functioning IT infrastructure, HIPAA compliant, electronic connection to State IT, and capability to communicate with providers electronically; (Attachment I, 3.1)** (2) **Submission of consumer screening, admissions, and eligibility data (Attachment I, 3.3)** (3) **Analysis of services authorizations and claims data; (Attachment I, 3.4)** (4) Timely response to data requests; (Contract 10.0 (6) (5) **Informative, user-friendly website with current (evergreen) information. (Attachment I, 3.5)**
Claims Processing	(1) **Process for prompt payment of claims(Attachment I, 4.1)** (2) **Process to identify all relevant payer information for each consumer**; **(Attachment I, 4.1)** (3) Process to pursue all applicable first and third party payments for services; (Attachment I, 4.2) (4) Identification of all payer information for each consumer (Attachment I, 4.2)

Provider Relations	(1) Annual review and update of the assessment of community need and provider capacity with 3rd quarter progress update, and quarterly updates reported to Board & CFAC; (Attachment I, 5.1) (2) ***Minimum number of provider agencies for every service necessary to ensure consumer choice; (Attachment I, 5.2)*** (3) ***Process for timely enrollment and enforcement of enrollment requirements; (Attachment I, 5.4.2)*** (4) Appropriate provider manual, trainings and technical assistance; (Attachment I, 5.3 & 5.6) (5) ***Process for ongoing evaluation and monitoring of provider quality and compliance with data submission requirements; (Attachment I, 5.5)*** (6) Process for resolving provider complaints. (Attachment I, 5.7)
Access / Screening, Triage and Referral	(1) ***Toll-free phone line; (Attachment I, 6.1)*** (2) ***24-hour access 365 days a year; (Attachment I, 6.1)*** (3) ***Calls answered within 30 seconds by qualified professional; (Attachment I, 6.1)*** (4) ***TTY and/or Relay capability and foreign-language interpreter; (Attachment I, 6.1)*** (5) ***Ability to schedule appointments with an appropriate provider within 24 hours of initial contact; (Attachment I, 6.1)*** (6) Process for managing DMHDDSAS bed-day allocations; (Attachment I, 6.4) (7) Report to Board and CFAC on access patterns and trends; (Attachment I, 1.2) (8) Screening consumers using the standard state form or all of the elements of the standard form. (Attachment I, 6.2)

Service Management (UM, Care Coordination, Community Collaboration, and SOC)	(1) Published Consumer Benefit Plan; (Attachment I, 7.1.1) (2) **Implementation of approved LME crisis services plan; (Attachment I, 7.1.2)** (3) Process for review of person-centered plans; (Attachment I, 7.1.3) (4) **Service authorization decisions within required timelines; (Attachment I, 7.1.4)** (5) **Notification to consumers of rights and appeals regarding LME service authorization decisions; (Attachment I, 7.1.5)** (6) ***Audit and Post-payment review of services by licensed staff***; **(*Attachment I, 7.1.6)*** (7) ***Management and prioritization of requests for Waiver services; (Attachment I, 7.1.7)*** (8) **Coordination of care for high cost/high risk consumers and consumers without a clinical home; (Attachment I, 7.2.1 & 7.2.2)** (9) **Active collaborative relationships with other human service agencies**; **(Attachment I, 7.3.1 & 7.4.3)** (10) Activities to encourage use of natural and community supports; (Attachment I, 7.3.3) (11) Full-time System of Care coordinator; (Attachment I, 7.4.1) (12) Designated staff to coordinate deaf services, school-based child and family teams, and development of housing opportunities (if applicable); (Attachment I, 7.2.3 & 7.3.5 & 7.4.2) (13) Quarterly Report to the Board on service utilization patterns. (Attachment I, 1.2 & 8.4)
Consumer Affairs and Customer Service	(1) **A customer service staff person shall respond to inquires within one business day. (Attachment I, 8.3)** (2) Outreach/education activities and materials (English & Spanish); (Attachment I, 8.2) (3) **Consumer Manual**; **(Attachment I, 8.3)** (4) Timely response and resolution (disposition) to consumer questions and complaints; (Attachment I, 8.4) (5) Staff support to the CFAC and Human Rights Committees; (Attachment I, 8.1) (6) Report to Board, human rights committee and CFAC on consumer incidents, complaints, appeals, and satisfaction with services at least quarterly. (Attachment I, 1.2 & 8.4)

Quality Management	(1) **Timely identification and remediation of problems; (Attachment I, 9.1)** (2) Production and review of regular management reports; (Attachment I, 9.2) (3) **Collection and submission of consumer data; (Attachment I, 9.3)** (4) **Analysis and use of data for planning, decision making and improvement; (Attachment I, 9.4)** (5) Active Quality Improvement committee; (Attachment I, 9.4) (6) Report on QI activities to Board and CFAC quarterly and to DMHDDSAS annually. (Attachment I, 1.2 & 9.4)

2.1 Compliance with DMHDDSAS Reporting Requirements

The DMHDDSAS shall calculate quarterly the LME's compliance with requirements for reporting information, as described in this contract and DMHDDSAS policies. The DMHDDSAS will review measures to identify comparative patterns and trends in order to evaluate areas of strength and weakness in the LME's compliance. Results will be published quarterly, as described in Section 1.0 of this Attachment. The DMHDDSAS shall maintain a current listing of all reporting requirements on the DMH/DD/SAS website at http://www.ncdhhs.gov/mhddsas/performanceagreement/index.htm

3.0 System Performance Indicators

DMHDDSAS will use the following measures to monitor the LME's performance on functional areas that have a direct impact on consumer care. DMHDDSAS will review measures to identify comparative patterns and trends in order to evaluate areas of strength and weakness in the LME's performance. Results will be published quarterly, as described in Section 1.0 of this Attachment.

A standard for expected performance is assigned to each measure, based on the statewide average for the second quarter of the previous fiscal year, as reported in the *MH/DD/SAS Community Systems Progress Report,* available on the DMH/DD/SAS website at http://www.ncdhhs.gov/mhddsas/statspublications/reports/index.htm. DHHS will use performance below the expected level on one or more measures as a signal that further on-site review of the LME's functions may be needed. NOTE: The SFY 2010-2011 Performance Standards will be reviewed mid-year and revised, if needed, to reflect the impact of budget and programmatic changes.

Comment [I1]:
FOOTNOTE to LMEs:

ATTACHMENT II & Section 3.0
1.System Performance Indicators will be updated based upon finalization of the DHHS Performance Contract indicators and specific alignment as well with the DMA Quality Performance Measures expected of the Waiver Entity.

2. Standardized Encounter Data and Data submission is required and dependent upon the acceptance of Medicaid data and DHHS going on line with the new OMMIS system, a Waiver Entity may need to down load waiver data back to start date of the LME operating as a LME-MCO.

3.1 Timely Access to Care Indicators

Rationale: Timely access to appropriate care is critical to protect consumer health and safety, minimize adverse consumer outcomes and promote consumer engagement in services. The timely access measures are based on Healthcare Enterprise Data Information System (HEDIS ©) measures, supported by the federal Centers for Medicaid and Medicare.

3.1.1 Timely Emergent Care

Performance Standard: Percent of persons starting a new episode of care who are in crisis and receive access to face-to-face emergency mh/dd/sa care within no more than two hours after the request for care is initiated.

Measurement:
The LME will report quarterly (1) the number of persons requesting service for a new episode of care through the LME Access Unit, (2) the number who are determined to need emergency care, and of those, (3) the number for whom face-to-face emergency care is available within two hours of the request and (4) the number who receive care within two hours of the request. The DHHS will review a random sample of emergent services annually to verify that the information submitted is accurate. Access to emergency care is defined as having a qualified provider on the physical premises ready to provide care as soon as the consumer is available to receive it. A new episode of care is defined by having no state- or federally-funded claim-based service (including paid claims, shadow claims, and claims denied for fiscal reasons) within the last 60 days.

3.1.2.1 Timely Urgent Care – Appointments Scheduled
Performance Standard: Percent of persons starting a new episode of care who are in need of urgent mh/dd/sa services and who are offered or scheduled for an appointment for their first service (assessment and/or treatment) within 48 hours of the request for care.

3.1.2.2 Timely Urgent Care – Appointments Kept
Performance Standard: Percent of persons starting a new episode of care who are in need of urgent mh/dd/sa services and receive their first face-to-face service (assessment and/or treatment) within 48 hours of the request for care.

Measurement:
Each LME shall report quarterly (1) the number of persons requesting service for a new episode of care through the LME Access Unit, (2) the number who are determined to need urgent care, and of those, (3) the number who are offered but decline an appointment within 48 hours of the request for care, (4) the number who are scheduled for an appointment within 48 hours and (5) the number who are seen face-to-face within 48 hours of the request for care. The DHHS will review a random sample of urgent services annually to verify that the information submitted is accurate. A new episode of care is defined by having no state- or federally-funded claim-based service (including paid claims, shadow claims, and claims denied for fiscal reasons) within the last 60 days.

3.1.3.1 Timely Routine Care – Appointments Scheduled
Performance Standard: Percent of persons starting a new episode of care who are in need of routine mh/dd/sa services and have a scheduled appointment for their first face-to-face service (assessment and/or treatment) within 14 calendar days of the request for care.

3.1.2.2 Timely Routine Care – Appointments Kept
Performance Standard: Percent of persons starting a new episode of care who are in need of routine mh/dd/sa services and receive their first face-to-face service (assessment and/or treatment) within 14 calendar days of the request for care.

Measurement:
Each LME shall report quarterly (1) the number of persons requesting service for a new episode of care through the LME Access Unit, (2) the number who are determined to need routine care, and of those, (3) the number who are offered but decline an appointment within 14 calendar days of the request for care, (4) the number who are scheduled for an appointment within 14

calendar days of the request for care and (5) the number who are seen face-to-face within 14 calendar days of the request for care. The DHHS will review a random sample of routine services annually to verify that the information submitted is accurate. A new episode of care is defined by having no state- or federally-funded claim-based service (including paid claims, shadow claims, and claims denied for fiscal reasons) within the last 60 days.

3.2 Treated Prevalence Indicator

Rationale: The public system is charged with serving all NC residents who have inadequate personal resources and are in need of specialized mh/dd/sa services, commensurate with available resources. Because services to persons with substance abuse services have declined substantially over recent years, the DMHDDSAS is continuing a priority of increasing services to these individuals.

Measurement:
DMHDDSAS will analyze CDW admissions and IPRS and Medicaid service claims data quarterly to determine the number of persons in each age-disability group who received at least one mental health service in the past four quarters. Treated prevalence will be calculated as the number of persons in the group served divided by the national prevalence estimate, as determined below.

3.2.1 Adult Mental Health (AMH) Services

SFY 2010 Performance Standard: Achievement and maintenance of the most current annual state average of 42%, as reported in the *MH/DD/SAS Community Systems Progress Indicators Report for Second Quarter SFY 2008-2009*.

Prevalence Estimate:
A national prevalence estimate for North Carolina is determined by the federal Center for Mental Health Services annually. The most recent statewide prevalence estimate is that 5.5% of adults ages 18 and above have a serious mental illness in any given year.

3.2.2 Child/Adolescent Mental Health (CMH) Services

SFY 2010 Performance Standard: Achievement and maintenance of the most current annual state average of 47%, as reported in the *MH/DD/SAS Community Systems Progress Indicators Report for Second Quarter SFY 2008-2009.*

Prevalence Estimate:
According to the most recent national prevalence estimate, as determined by the federal Center for Mental Health Services, 12% of children and adolescents ages 0-17 have a serious emotional disturbance in a given year. Because the NC public health system is responsible for serving children from birth through age 2, the prevalence estimate will be applied to the LME's population ages 3-17.

3.2.3 Adult Developmental Disability (ADD) Services

SFY 2010 Performance Standard: Achievement and maintenance of the most current annual state average of 38%, as reported in the *MH/DD/SAS Community Systems Progress Indicators Report for Second Quarter SFY 2008-2009.*.

Prevalence Estimate:

The national prevalence estimate, as determined by the 1994-1995 National Health Interview Survey, is that 0.79% of adults ages 18 and above has a developmental disability.

3.2.4 Child/Adolescent Developmental Disability (CDD) Services

SFY 2010 Performance Standard: Achievement and maintenance of the most current annual state average of 20%, as reported in the *MH/DD/SAS Community Systems Progress Indicators Report for Second Quarter SFY 2008-2009.*

Prevalence Estimate:
The national prevalence estimate, as determined by the 1994-1995 National Health Interview Survey, is that 3.21% of children and adolescents ages 0-17 have a developmental disability. Because the NC public health system is responsible for serving children from birth through age 2, the prevalence estimate will be applied to the LME's population ages 3-17.

3.2.5 Adult Substance Abuse (ASA) Services

SFY 2010 Performance Standard: Achievement and maintenance of the most current annual state average of 8%, as reported in the *MH/DD/SAS Community Systems Progress Indicators Report for Second Quarter SFY 2008-2009.*

Prevalence Estimate:
The national prevalence estimate for North Carolina, as determined by the 2005 and 2006 National Survey of Drug Use and Health, is that 18.8.7% of adults ages 18-25 and 6.84% of adults ages 26 and above have a substance abuse problem in any given year.

3.2.6 Adolescent Substance Abuse (CSA) Services

SFY 2010 Performance Standard: Achievement and maintenance of the most current annual state average of 7%, as reported in the *MH/DD/SAS Community Systems Progress Indicators Report for Second Quarter SFY 2008-2009* and adjusted to reflect the county-level modifier.

Prevalence Estimate:
The national prevalence estimate for North Carolina, as determined by the 2005 and 2006 National Survey of Drug Use and Health, is that 7.83% of adolescents ages 12-17 have a substance abuse problem in any given year.

3.3 Timely Initiation of Service Indicator

Rationale: Timely initiation of appropriate, ongoing service is critical to protect consumer health and safety, minimize adverse consumer outcomes and promote consumer engagement in services. This is a Washington Circle Public Sector Workgroup measure, supported by SAMHSA.

SFY 2010 Performance Standard: Achievement and maintenance of the most current annual state average for each disability group, as reported in the *MH/DD/SAS*

Community Systems Progress Indicators Report for Second Quarter SFY 2008-2009, or SFY 2009 Standard, if higher.

Measurement:
The DMHDDSAS will calculate quarterly the time between the first and second service events (assessment and/or treatment) for each consumer starting a new episode of care, based on IPRS and/or Medicaid paid service claims data, to determine the percent of new consumers who received at least two services in the first 14 calendar days of care. A new episode of care is defined by having no state- or federally-funded claim-based service, except for medication management, for at least 60 days.

3.3.1 Persons Receiving Mental Health Services
(Standard = 41%;)

3.3.2 Persons Receiving Developmental Disability Services and Supports
(Standard = 70%;)

3.3.3 Persons Receiving Substance Abuse Services
(Standard = 64%;)

3.4 Timely Engagement in Service Indicator
Rationale: Timely continuation of appropriate service is critical to protect consumer health and safety, minimize adverse consumer outcomes and promote consumer engagement in services. This is a Washington Circle Public Sector Workgroup measure, supported by SAMHSA.

SFY 2010 Performance Standard: Achievement and maintenance of the most current annual state average for each disability group, as reported in the *MH/DD/SAS Community Systems Progress Indicators Report for Second Quarter SFY 2008-2009,* or SFY 2009 Standard, if higher.

Measurement:
The DMHDDSAS will calculate quarterly the time between the second and fourth service events (assessment and/or treatment) for each consumer who received a second service within the first 14 days of care (i.e. consumers who met the standard for Measure 1.3), based on IPRS and/or Medicaid paid service claims data, to determine the percent of consumers starting a new episode of care who received at least two additional services in the next 30 calendar days of care.

3.4.1 Persons Receiving Mental Health Services
(Standard = 27%;)

3.4.2 Persons Receiving Developmental Disability Services and Supports
(Standard = 59%;)

3.4.3 Persons Receiving Substance Abuse Services
(Standard = 47%;)

3.5 State Psychiatric Hospital Use Indicators

3.5.1 Short-Term State Psychiatric Hospital Use Indicator

Rationale: Serving individuals in need of short-term crisis services in their home communities and in the least restrictive setting appropriate helps families to stay in touch and reserves high-cost state psychiatric hospital beds for individuals in need of long-term care. This is a Mental Health Block Grant measure required by the Center for Mental Health Services.

SFY 2010 Performance Standard: Achievement and maintenance of the most current state average of no more than 46%, as reported in the *MH/DD/SAS Community Systems Progress Indicators Report for Second Quarter SFY 2008-2009*.

Measurement:
The DMHDDSAS will calculate the lengths of stay of individuals discharged from a state psychiatric hospital each quarter, as recorded in the Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) to determine the number of individuals with lengths of stay of 1-7 days as a percent of total discharged individuals for the quarter.

3.5.2 Psychiatric Hospital Readmissions

Rationale: Individuals who receive appropriate community-based services, especially following inpatient care, will experience fewer crises and attain a more stable recovery. An individualized crisis plan, developed through person-centered planning, can help to prevent crises and ensure that crises that do arise can be addressed without further hospitalization. This is a Mental Health Block Grant measure required by the Center for Mental Health Services.

3.5.2.1 Hospital Readmissions within 30 Days

SFY 2010 Performance Standard: Achievement and maintenance of the most current state average of no more than 10% of persons discharged from a state psychiatric hospital are readmitted within 1-30 days, as reported in the *MH/DD/SAS Community Systems Progress Indicators Report for Second Quarter SFY 2008-2009*.

Measurement:
The DMHDDSAS will calculate the number of individuals readmitted to a state psychiatric hospital within 1-30 days as a percent of individuals discharged from a state psychiatric hospital each quarter, as recorded in HEARTS.

5.3.2.2 Hospital Readmissions within 180 Days

SFY 2010 Performance Standard: Achievement and maintenance of the most current state average of no more than 22% of persons discharged from a state psychiatric hospital are readmitted within 1-180 days, as reported in the *MH/DD/SAS Community Systems Progress Indicators Report for Second Quarter SFY 2008-2009*.

Measurement:

The DMHDDSAS will calculate the number of individuals readmitted to a state psychiatric hospital within 1-180 days as a percent of individuals discharged from a state psychiatric hospital each quarter, as recorded in HEARTS.

3.6. Continuity of Care after State-Operated Inpatient Services Indicator

Rationale: Timely follow-up care is critical to minimize adverse consumer outcomes, prevent the need for re-hospitalization, and promote recovery.

3.6.1 Follow-Up after Discharge from a State Psychiatric Hospital

SFY 2010 Performance Standard: Achievement and maintenance of the most current state average of 35%, as reported in the *MH/DD/SAS Community Systems Progress Indicators Report for Second Quarter SFY 2008-2009*.

Measurement:
The DMHDDSAS will compare quarterly each consumer's date of discharge from a state psychiatric hospital, as recorded in HEARTS, to the consumer's first date of service (assessment and/or treatment) paid through an Integrated Payment & Reporting System (IPRS) and/or Medicaid service claim to determine the number of persons receiving a community-based service within 7 days of discharge as a percent of all persons discharged during the quarter.

3.6.2 Follow-Up after Discharge from a State Alcohol and Drug Abuse Treatment Center

SFY 2010 Performance Standard: Achievement and maintenance of the most current state average of 26%, as reported in the *MH/DD/SAS Community Systems Progress Indicators Report for Second Quarter SFY 2008-2009*.

Measurement:
The DMHDDSAS will compare quarterly each consumer's date of discharge from a state ADATC, as recorded in HEARTS, to the consumer's first date of service (assessment and/or treatment) paid through an Integrated Payment & Reporting System (IPRS) and/or Medicaid service claim to determine the number of persons receiving a community-based service within 7 days of discharge as a percent of all persons discharged during the quarter.

3.7 Child Services in Non-Family Settings

Rationale: Children and adolescents served in the most natural and least restrictive community settings appropriate to their needs are more likely to maintain or develop positive family and community connections and to achieve other lasting, positive outcomes.

SFY 2010 Performance Standard: Achievement and maintenance of the most current state average of 4%, as reported in the *MH/DD/SAS Community Systems Progress Indicators Report for Second Quarter SFY 2008-2009*.

Measurement:

The DMHDDSAS will calculate the number of children receiving Level II (Program Type only), Level III and/or Level IV residential services each quarter, according to Integrated Payment & Reporting System (IPRS) and/or Medicaid service claims, as a percent of all children served by the LME.

Attachment III
FINANCING

1.0 Systems Management Funding

The LME shall be paid monthly an annual allocation from the base year of 20XX, as delineated in Attachment V. The payment is based upon the cost for an efficient Waiver Systems Manager.

The Waiver Systems Management payment will be funded entirely by the Department. If a county chooses to provide additional funding for Systems Management functions, such additional funding must be in addition to the funding required of counties by G.S. 122C-115.

The Waiver Systems Management payment will cover the following LME functions which are more fully described in the Scope of Work.

(1) General Administration and Governance;
(2) Business Management and Accounting;
(3) Information Management Analysis and Reporting;
(4) Claims Processing;
(5) Provider Relations and Support;
(6) Access, Screening, Triage and Referral;
(7) Service Management (Utilization Management, Service Coordination and Community Collaboration);
(8) Consumer Affairs and Customer service;
(9) Quality Improvement and Outcomes Evaluation.

1.1 Expansion or Reduction in Funding:
In the event the Division receives an expansion in state appropriation funding and/or an increased in federal funding for community MH/DD/SA services, or if the state or federal funding is reduced, the state and federal allocation will be adjusted in accordance with the formula used for all other LME's.

1.2 Additional Equity Adjustments:
State and federal funds will be adjusted in accordance with the plan implemented by the Division to adjust allocations to all Local Management Entities (LMEs) to distribute funding more equitably.

1.3 State Hospital Resource Adjustments:
The Department of Health and Human Services will determine funding adjustments, if applicable, from the State Facilities. State Institutions Resources may be included in the LME NAME allocations as the allocations of State psychiatric hospital resources are moved entirely to a per capita basis. Adjustments may be made based upon the State Hospital Resources.

Comment [I2]:
FOOTNOTE TO LMEs:

ATTACHMENT III FINANCING
****PLACEHOLDER LANGAGE****

DMHDDSAS financing section will change based upon several variables still being worked on with DHHS, DMHDDSAS, State Controllers Office and DSOHCF. The below bulleted items will worked into the final waiver contract.

❖TRANSFER OF FUNDS from the State facilities will not occur for the next "XX" years.

❖ DHHS WILL NEGOITIATE with State Facilities (DSOHCF) Waiver Entity to transition from pure state bed allocation to payment for beds.

❖ WAIVER SITES over a period of time will pay market rate for state hospital beds as part of the waiver.

❖ DHHS / DSOHCF will develop differential rates for different hospital program beds (i.e. acute care admissions vs. long-term care beds). For the first three years of the DMA contract, the MCO is required to maintain state-established rates for ICF-MRs and established procedures for timely filling of beds.

❖ IN THE DMA CONTRACT, for the first three years, the MCO is required to maintain state-established rates for ICF-MRs and established procedures for timely filling of beds.

❖ 9.5% administrative fee identified below subject to change based upon Mercer's Medicaid capitated calculations and the LME – MCO function and the LME contracting out service treatment planning.

1.4 Administrative Limits:
The following limits apply to funding for LME Administrative activities. The LME may take a 9.5% administrative fee from its state and federal allocation. A LME administrative expense report is required. The LME is responsible for covering administrative cost related to management of state and federal services within the 9.5% administrative fee.

2.0 Services Funding:

2.1 Settlement for Service Funding:
No year-end refund from LME NAME to DMHDDSAS is required if LME NAME's allowable IPRS shadow claims* reported program specific payments and /or sub-capitation payments made directly to service providers, and LME NAME's payments to State facilities meet or exceed the value of the funds received from DMHDDSAS. In the event the value of allowable shadow claims and payments to State facilities do not meet or exceed the amount of funds LME NAME received from DMHDDSAS, LME NAME may provide supplemental information on allowable documented actual expenditures including but not limited to program specific non-UCR payments and sub-capitation payments made to service providers, which do not duplicate the value of the allowable shadow claims. If LME NAME payments to State facilities plus LME NAME allowable documented actual expenditures noted above are less than the amount of payment from DMHDDSAS to LME NAME, LME NAME shall refund the excess funds to the Division. For the purpose of settlement of service funds, service funds are defined as all payments from DMHDDSAS to LME NAME, less 9.5% of such amount for administration as set forth in Section 1.4, Administrative Limits, above.

*An "allowable IPRS shadow claim" is defined as a claim submitted to the Integrated Payment and Reporting system (IPRS) and processed successfully to render a budget/fiscal denial [EOB 8505] . (IPRS will be eventually replaced by a new OMMIS system so name and terminology subject to change.)

2.2 Utilization and Payment for State Facilities:
The LME will submit to the Department annually by March 1, of each year, a plan for the LME's utilization of State facilities, by bed type, for the upcoming fiscal year… (SECTION TO BE FURTHER DEVELOPED BASED UPON COMMENTS CITED ABOVE IN COMMENT BOX). .

The LME Director shall serve as the Division Director's designee in approving admission to State psychiatric hospitals in accordance with G.S. 122C-261(f)(4), the Thomas S. Diversion Law. In so doing, the LME Director shall ensure every effort has been made to identify an appropriate alternative treatment location prior to approving the admission to a state psychiatric hospital.

3.0 Single Stream Funding

A LME that is approved by DMHDDSAS to receive single stream funding shall be required to follow the Division's most currently published standards for single stream funding initial qualifications, continuing designation, removal, and reinstatement

following removal. These standards are published on the Division's web site.

A LME that is approved by DMHDDSAS to receive single-stream funding shall continue to enroll individuals into the appropriate population group and to report service units to the Integrated Payment and Reporting System (IPRS). Reporting to IPRS shall contain accurate and complete content to allow either (a) claims payment through the appropriate source of Federal funds not included in single-stream funding or (b) processing of claims until a 'budget/fiscal deny for no budget [EOB 8505]' is received by the LME for insufficient budget.

Except as noted herein, a LME that receives single-stream funding shall use Division funding only to purchase services included in the IPRS service array. If the LME desires to provide services not included in the IPRS service array, the LME shall submit the *LME Alternative Service* Request for Use of DMH/DD/SAS *State Funds* as outlined in the DMH correspondence to LME Directors dated April 22, 2008.

Each LME receiving single stream funding shall meet or exceed the DMH designated Maintenance of Effort (MOE) requirements for state only funding by LME for SFY 08-09 in accordance with the Division's federal mandates in the current applicable Substance Abuse Prevention and Treatment Block Grant (SAPTBG) and the Mental Health Block Grant (MHBG). The MOE requirement for SFY 11 is defined as the amount of State funding allocated in SFY 11, with adjustments in State funding, including any increases or decreases, for SFY 11.

Required expenditures by LME of state appropriated funds for substance abuse treatment services shall be reported in IPRS and shall fully address both the overall SAPTBG MOE for substance abuse treatment expenditures and the Women's MOE for substance abuse treatment expenditures for pregnant women and women with dependent children.

Required expenditures by LME of state appropriated funds for mental health treatment services shall be reported in IPRS and shall fully address both the overall MHBG MOE for mental health treatment expenditures and the Child Mental Health Services MOE for mental health treatment expenditures for children and adolescents under the age of 18.

The DMH shall pay LMEs operating under single-stream funding 1/12th of the allocated state funds on or about the 10th day of July subject to cash availability. Subsequent payments shall be made on or about the 10th day of the following month subject to cash availability and if the LME's reporting of service units and/or expenditures during the previous month has adequately documented earnings.

Year-end settlement of DMH allocated funds paid to the LME via the single stream 1/12th methodology shall be as follows:

- **a.** If the value of allowable shadow claims submitted through IPRS are equal to or exceed the total single stream funding payments for the year, no refund shall be due to the Division by the LME;
- **b.** In the event the value of allowable IPRS shadow claims are not equal to or greater than Division single stream payments noted above, the LME may provide supplemental information on allowable documented actual expenditures,

including but not limited to program specific non-UCR payments, which do not duplicate the value of allowable shadow claims. If the total value of the LME's allowable IPRS shadow claims plus the LME's documented and Division approved actual expenditures are equal to or greater than Division single stream payments noted above, no refund shall be due to the Division by the LME.

c. If, after determining the utilization of Division funds as set forth in item b. above, the total value of services is less than the amount paid to the LME in Division single stream payments noted above, the LME shall refund the difference to the Division, minus up to 15% of the total allocation of State funds to be retained in the subsequent fiscal year for service provision.

d. For the purpose of settlement, an allowable IPRS shadow claim is defined as an IPRS claim which processes to render a budget/fiscal deny [EOB 8505].

e. The settlement process will be completed by December 31 of each year, subject to adjustment, as necessary, based upon the LME's final audit.

4.0 Reservation of Funds for Utilization in Subsequent Fiscal Years

4.0.1 This section applies only to multi-county LMEs and not single county programs.

4.0.2 Funds otherwise required to be reserved by North Carolina General Statutes or as otherwise determined by the independent auditor, do not require prior approval from DMHDDSAS and are not impacted by items 4.0.3 and 4.0.4 below.

4.0.3 The portion of fund balance that is designated by the Area Board may be excluded in the DMHDDSAS determination of the 15% unrestricted fund balance. To be excluded, such designation must first be approved by the Area Board and then the LME must have secured approval from DMHDDSAS for the designation. Prior approval is to be requested in writing to the Division's Budget and Finance Team who will then respond in writing to the LME within thirty (30) days after receipt of the request. At a minimum, requests submitted by LMEs to the Division shall include: (i) amount of funds requested for designation by purpose, (ii) a detailed justification for the proposed utilization of the funds requested for designation by purpose, including a timetable for expending the designated funds, (iii) impact analysis, by purpose, if the request(s) to designate funds is not approved by DMHDDSAS, and (iv) copy of the LME Board minutes which reflect the Board's approval to request the designation of such funds. Such requests for designation must be submitted to the Division prior to June 15th of the year in which the funds are available for designation to allow review and action prior to fund balance computations for the year.

4.0.4 In the event the unrestricted fund balance for any year is in excess of the fifteen percent (15%) which the LME may retain, the fund balance amount above 15% is to be handled in accordance with 10A NCAC 27A .0111.

5.0 Disallowances

Any funds or part thereof transferred by DMHDDSAS to the LME shall be subject to reimbursement by the LME to DMHDDSAS in the event those funds are disallowed pursuant to a State or federal audit.

6.0 Restrictions on the Expenditure of Substance Abuse Prevention and Treatment Block Grant (SAPTBG) Funds, Community Mental Health Services Block Grant (CMHSBG) Funds and PATH formula grant funds.

1. CMHSBG and SAPTBG funds are prohibited to be used to provide or purchase inpatient hospital services, except for SAPTBG funds may be used with exception as described in 45 CFR 96.135 (c)*.

2. CMHSBG and SAPTBG funds are prohibited to be used to make, or to allow to be made, any cash payments to any recipients or intended recipients of health or behavioral health services.

3. CMHSBG and SAPTBG funds are prohibited to be used to make, or to allow to be made, any cash payments to any recipients or intended recipients of health or behavioral health services.

4. CMHSBG and SAPTBG funds are prohibited to be used for the purchase or improvement of land, purchase, construction or permanent improvement (other than minor remodeling) of any building or other facility, or purchase of major equipment, including medical equipment.

5. CMHSBG and SAPTBG funds are prohibited to be used to satisfy any requirement for the expenditure of non-Federal funds as a condition of receipt of Federal funds. *(i.e. Federal funds may not be used to satisfy any condition for any state, local or other funding match requirement)*.

6. CMHSBG and SAPTBG BG funds are prohibited to be used to provide financial assistance to any entity other than a public or nonprofit private entity.

7. CMHSBG and SAPTBG funds are prohibited to be used towards the annual salary of any LME, provider, or contractor employee, consultant, or other individual that is in excess of Level I of the most current US Office of Personnel Management federal Executive Salary Schedule.

8. SAPTBG funds are prohibited to be used to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs

9. SAPTBG funds are prohibited to be used to provide individuals with treatment services in penal or correctional institutions of the State (This includes jails, prisons, adult and juvenile detention centers, juvenile training schools, etc.)

10. PATH formula grant funds shall not be expended on:

(A) to support emergency shelters or construction of housing facilities;
(B) for inpatient psychiatric treatment costs or inpatient substance abuse treatment costs; or
(C) to make cash payments to intended recipients of mental health or substance abuse services.

*** Note Exception for substance abuse inpatient hospital services under the SAPTBG is as follows:**

45 CFR Part 96.135 (c) Exception regarding inpatient hospital services.

(1) With respect to compliance with the agreement made under paragraph (a) of this section, a State (acting through the Director of the principal agency) may expend a grant for inpatient hospital-based substance abuse programs subject to the limitations of paragraph (c)(2) of this section only when it has been determined by a physician that:

(i) The primary diagnosis of the individual is substance abuse, and the physician certifies this fact;

(ii) The individual cannot be safely treated in a community-based, nonhospital, residential treatment program;

(iii) The Service can reasonably be expected to improve an individual's condition or level of functioning;

(iv) The hospital-based substance abuse program follows national standards of substance abuse professional practice; and

(2) In the case of an individual for whom a grant is expended to provide inpatient hospital services described above, the allowable expenditure shall conform to the following:

(i) The daily rate of payment provided to the hospital for providing the services to the individual will not exceed the comparable daily rate provided for community-based, nonhospital, residential programs of treatment for substance abuse; and

(ii) The grant may be expended for such services only to the extent that it is medically necessary, i.e., only for hose days that the patient cannot be safely treated in a residential, community-based program.

Attachment IV

DATA USE AGREEMENT

Comment [GM3]: Will add a new Attachment VI—the CCNC Informatics data agreement.

Will need to be signed and maintained by LME.

This Data Use Agreement ("DUA") between the North Carolina Department of Health and Human Services ("Department") and the Local Management Entity ("LME") whose name is printed at the end of this DUA shall be effective from and after the date of its execution by both parties and shall remain in effect throughout the term of the Master Agreement to which it is attached, including any option years.

WHEREAS, N.C. Gen. Stat. § 122C-115.4(a) provides that "Local management entities are responsible for the management and oversight of the public system of mental health, developmental disabilities, and substance abuse services at the community level. An LME shall plan, develop, implement, and monitor services within a specified geographic area to ensure expected outcomes for consumers within available resources";

WHEREAS, the statutory functions of the LME include screening, triage and referral, utilization management, care coordination, and financial accountability and management;

WHEREAS, the Department and the LME agree that the LME needs access to certain mental health, developmental disability and substance abuse paid claims data compiled by the Department in order for the LME to perform the duties assigned to it by N.C. Gen. Stat. § 122C-115.4;

WHEREAS, the LME and the Division agree that the Division needs access to certain mental health, developmental disability and substance abuse LME NAME Medicaid Waiver encounter data compiled by the LME as a Waiver Entity Project in order for the Division to perform the duties to it as outlined in "Attachment II – Performance Expectations" of this contract measuring the performance of LMEs as indicated is GS122C-102(c).

WHEREAS, the Department and the LME each represents to the other that it is a "Covered Entity", as that term is defined by the 45 CFR § 160.103;

WHEREAS, the Parties believe that the disclosures described by this Attachment are properly made for the purpose of "Health Care Operations," pursuant to 45 CFR § 164.506(c)(4) and paragraph (1) of the definition of "Health Care Operations" in 45 CFR § 164.501;

NOW THEREFORE, the Parties agree as follows:

1. The LME shall provide the Division with the mental health, developmental disability, and substance abuse Medicaid encounter data described in Attachments A and B to this DUA.

2. The Division shall provide the LME with the mental health, developmental disability, and substance abuse Hearts claims data described in Attachments A and B to this DUA.

3. The paid claims data provided to the DMH shall be limited to data that pertains to:

   a. Eligible recipients whose county of eligibility lies within the LME's catchment area; and

   b. Eligible recipients whose county of eligibility lies outside of the LME's catchment area who nonetheless receive services from providers located within the LME's catchment area.

4. The mental health and developmental disability paid claims data provided to the LME shall include individually identifiable health information, as defined in 45 CFR § 160.103;

5. The substance abuse paid claims data provided to the Division shall not include individually identifiable health information.

6. The Division and the LME shall use the data, excluding Medicaid SA service data, solely for the following purposes:

   a. To fulfill the Divisions obligations as outlined in N.C. Gen. Stat. § 122C-115.4, which holds the LME "responsible for the management and oversight of the public system of mental health, developmental disabilities, and substance abuse services within a specified geographic area . . . ."

7. The LME agrees that it shall not use or disclose the data for any purposes not described in paragraph 5 of this Amendment unless the LME first obtains the Department's prior consent for the use or disclosure pursuant to the DMHDDSAS Privacy and Security Policies in effect at the time of the use or disclosure.

8. The Department may suspend or revoke this Attachment, with or without notice, if it discovers that the LME has used or disclosed the data for any unauthorized purpose or that the LME has failed to protect the data in the manner prescribed in 45 CFR Parts 160, 162, and 164 or any other applicable law or regulation.

LME NAME

Signature Date

Printed Name Title

WITNESS

Signature Date

Printed Name Title

North Carolina Department of Health and Human Services

Secretary or Designee Date

Printed Name Title

ATTACHMENT IV
Part A

Mental Health and Developmental Disability Medical Paid Claims Data
To Be Provided in a Reciprocal Relationship Between The LME and The Division

A. An LME Monthly Medicaid Claims File for paid claims (paid>0) for residents of the LME's catchment area, based on the Medicaid county of eligibility, with the following characteristics:

1. Flat ASCII File, with a separate record for each detail paid Medicaid claim processed during the month

2. Posted to Secure FTP site

3. Contains the following information

    a. Client Medicaid Number, Name and DOB
    b. Billing Provider Code and Name
    c. Attending Provider Code and Name
    d. Type of service code and name
    e. Date of Payment
    f. Date of Service
    g. Paid Units
    h. Payment Amount

4. For these billing sources:

    a. Area Billed
    b. Enhanced Services
    c. Child Residential
    d. Direct Enrolled Behavioral Health Outpatient
    e. PRTF
    f. General Hospital with Psych DRG
    g. State Hospital Medicaid
    h. Non-State Psychiatric Hospital
    i. CAP MR/DD
    j. Criteria 5
    k. Direct Enrolled Psychiatrists
    l. State ICR SNF (Special Care/Black Mountain)
    m. ICF MR Community
    n. ICF MR State

ATTACHMENT IV
Part B

Substance Abuse Paid Claims Data
(Including Both Medicaid Claims Data And State-Funded, Non-Medicaid Claims Data)
To Be Provided in a Reciprocal Relationship Between the Division and The LME

A. An LME Monthly Medicaid Claims File for paid claims (paid>0) for residents of the LME's catchment area, based on the Medicaid county of eligibility, with the following characteristics:

1. Flat ASCII File, with a separate record for each detail paid Medicaid claim processed during the month

2. Posted to Secure FTP site

3. Contains the following information:

    a. Billing Provider Code and Name
    b. Attending Provider Code and Name
    c. Type of service code and name
    d. Date of Payment
    e. Date of Service
    f. Paid Units
    g. Payment Amount

4. For these billing sources:

    a. Area Billed
    b. Enhanced Services
    c. Child Residential
    d. Direct Enrolled Behavioral Health Outpatient
    e. PRTF
    f. General Hospital with Psych DRG
    g. State Hospital Medicaid
    h. Non-State Psychiatric Hospital
    i. CAP MR/DD
    j. Criteria 5
    k. Direct Enrolled Psychiatrists
    l. State ICR SNF (Special Care/Black Mountain)
    m. ICF MR Community
    n. ICF MR State

ATTACHMENT V
The LME NAME Demonstration Waiver Project

1.0 Purpose

The purpose of the North Carolina - LME NAME Demonstration Project is to develop the capacity to manage a system of care across a five county region that is based on the principles of Recovery, Self-Determination and Person Centered Planning, and which supports an organized delivery system of services and providers across all funding streams. This project will demonstrate an interactive, mutually supportive, and collaborative partnership between State Agencies and the Local Management Entity in the implementation of public policy at the local level.

2. Intra-Departmental Monitoring Team:

The Department will maintain an Intra-Departmental Monitoring Team to provide monitoring and oversight of this project through the course of the Demonstration Project. This Monitoring Team will meet a minimum of quarterly, and more often if needed. The Monitoring Team will further conduct an Annual on-site monitoring review. The Monitoring Team will assist the LME in further conduct an Annual on-site monitoring review. The Monitoring Team will assist the LME in addressing problems and question in implementing the project, achieving goals, and Performance targets. When problems or deficiencies occur in meeting Reporting Requirements, timeliness of information, and performance on Performance Indicators, the Monitoring Team will work with the LME to understand the reasons for the problems and assist in problem resolution by providing technical assistance. However, the Monitoring Team may require an Action Plan when deficiencies are severe or recurrent or if the LME fails to address noted deficiencies in a timely manner. The Action Plan will be monitored until the problem is resolved.

Members of the Intra-Departmental Monitoring Team shall include the representation from the following:

DMA:

1. Finance Management-Audit Section
2. Behavioral Health Medical Policy
3. Managed Care
4. Budget Management

DMH/DD/SAS:

1. Best Practice Team
2. Budget Team
3. LME Performance Team
4. Regulatory Team
5. Quality Management Team

LME – LME NAME:

1. Management
2. Finance
3. Operations (Access, Network, Waiver Implementation)
4. Quality
5. others to be identified if needed.

DHHS:

1. Office of the Controller
2. Office of Budget and Analysis

3 Scope of Monitoring Activities:

The Monitoring Team will conduct routine monitoring of the following in order to identify problems, deficiencies, and barriers to desired performance expectations and to develop improvement strategies, determine needs for a Corrective Action Plan, and to monitor any Corrective Action Plan in place:

a. Monitoring and Reporting: timeliness, completeness, data content, Attachment II – Section 1.0
b. Performance Indicators: timeliness, completeness and performance against goals, performance standards, and/or benchmarks. Attachment II – Section 3.0

4 Monitoring Process:

The Monitoring Team will use a Continuous Quality Improvement approach to review of the LME performance. The Team will routinely review, analyze, and interpret data. The purpose is to discover system performance problems, identify performance barriers, and develop improvement strategies, including Corrective Action Plans. The Team will monitor improvement strategies and Corrective Action Plans to ensure that identified problems are improved. The process is important to document both the challenges and successes of this LME Demonstration Project.

a. The Monitoring Team will meet a minimum of quarterly.
b. A regular agenda will be established identifying expected areas to be addressed:
    i. Performance
    ii. State concerns and questions
    iii. LME's challenges, barriers and need for assistance
    iv. Project successes
    v. Need for changes, improvements, or Action Plan for Correction
    vi. Progress on identified problems or Action Plans of Correction.

c. Minutes will be kept of all meetings.

5 Annual Monitoring Review:

DMA – DMH will conduct an Annual Monitoring Review on-site at the LME. The Monitoring Review will serve the purpose of observing and understanding the LME's operations as related to this Demonstration Project and will provide a review of the following:

a. Compliance with the requirements of this contract;
b. Compliance with State and Federal Medicaid requirements;
c. The LMEs compliance with G.S. 122C-112.1;
d. Implementation of the LME's Local Business Plan
e. To the extent possible, the review will not duplicate areas assessed by the National Accrediting Body (once LME accreditation has been achieved).
f. Compliance with requirements and restrictions of the SAPTBG, CMHSBG, SSBG, and their accompanying state MOE requirements, the PATH Program federal formula grant, SPF-SIG, SDFSCA, and other federally funded or designated projects.
g. Compliance with all state and federal laws and regulations.

Attachment VI
Baseline for Single Stream Funding for LME NAME

Comment [GM4]:

PLACE HOLDER FOR FINANCE AND BUDGET OFFICE UPON KNOWING THE LME TO BE AWARDED A LME-MCO Contract.

DMH/DD/SAS - LME NAME Contract
Attachment VI

Baseline for Single Stream Funding

Waiver Entity Project	Designated Waiver LME	LME partner(s)	Total
A. State/Federal Allocated Resources (S/FAR)			
1. Current Division Allocations (Excluding one-time allocations)			
CTSP	~~$2,959,857~~	~~$990,975~~	~~$3,950,832~~
State	~~$9,974,142~~	~~$3,231,567~~	~~$13,205,709~~
Early Childhood	~~$823,956~~	~~$237,171~~	~~$866,127~~
MR/MI	~~$3,263,890~~	~~$1,934,449~~	~~$5,253,339~~
Total State	~~$15,935,845~~	~~$6,371,052~~	~~$22,179,797~~
PATH	~~$15,660~~	~~$0~~	~~$15,660~~
MHBG	~~$414,809~~	~~$23,574~~	~~$438,383~~
SSBG	~~$220,146~~	~~$52,564~~	~~$272,710~~
Infants & Toddlers	~~$293,780~~	~~$131,859~~	~~$425,639~~
SAPTBG	~~$1,254,274~~	~~$194,495~~	~~$1,448,769~~
TANF	~~$0~~	~~$25,660~~	~~$25,660~~
Drug Free Schools	~~$53,824~~	~~$21,471~~	~~$80,295~~
Total Federal	~~$2,253,993~~	~~$448,623~~	~~$2,735,795~~
Grand Total	~~$18,189,838~~	~~$6,793,675~~	~~$24,915,592~~
Less: State and Federal ECI	~~($922,736)~~	~~($368,020)~~	~~($1,291,756)~~
Revised Total	~~$17,199,742~~	~~$6,425,655~~	~~$23,623,737~~

2. Equity Funding (Per Capita Adjustment)			
Statewide Median Per Capita	43.21	43.21	43.21
LME NAME Region Per Capita	35.20	41.33	
Difference	8.01	1.88	
Population	479,501	153,152	
Per Capita Difference Value	$3,840,503	$287,926	$4,128,429
50% of Per Capita Difference	$1,920,402	$143,963	$2,064,365
3. Total S/FAR			
Current Allocation	17,199,742	8,423,995	25,623,737
Equity Funding	1,920,402	143,963	2,064,365
Total	$19,120,144	$8,567,958	$27,688,102
B. State Institution Resources (SIR):			
Broughton Hospital	3,224,933	0	3,224,933
Dorothea Dix Hospital	0	1,795,193	1,795,193
Julian F. Keith ADATC	1,155,696	335,337	1,491,033
Value of Per Capital Difference, Psych. Hospitals Only	2,397,595	1,992,569	4,390,013
50% of Per Capita Difference	1,198,751	996,284	2,195,007
Total State Institutions Resources	7,579,372	3,126,739	10,706,161
C. Total PCPM			
S/FAR	19,120,144	8,567,958	25,688,102
SIR	7,579,372	3,126,739	10,706,161
Total	$26,699,516	$9,694,747	$36,394,263
July 1, 2010 Population	479,501	153,152	632,653
PCPM	$4.34	$5.23	$4.79

D. PCPM SFY 2003-2004 Only			
S/FAR	19,120,144	6,567,958	25,688,102
SIR	7,579,372	3,126,789	10,706,161
Total	26,699,516	9,694,747	36,394,263
(Less $1,000,000 Adjustment)	(1,000,000)	0	(1,000,000)
Adjusted Total	$25,699,516	$9,694,747	$35,394,263
July 1, 2010 Population	479,501	153,152	632,653
PCPM	$51.47	$63.29	$51.68

E. Capital Advance Requested			
SFY xxxx - xxxx Adjusted Total	25,699,516	9,694,747	35,394,263
Capital Advance of 6%	1,541,971	581,685	2,123,656

NOTE:
This schedule does not include information on Medicaid (which will be determined based upon an actuarial analysis), required county Maintenance of Effort, First and Third party benefits, or LME Fund balance.